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CAECOSTOMY.

By E. S. R. HUGHES,
Melbourne.

IN the treatment of acute large bowel obstruction caused by carcinoma, most surgeons agree that preliminary deflation of the large bowel should precede any attack on the primary tumour; but there is no uniformity of opinion as to how this is best achieved.

A perusal of recent literature and discussions with surgical colleagues indicate that surgeons are divided as to whether a caecostomy or a colostomy is preferable in these cases. For example, Wolfson and Greenberg (1953) have expressed themselves in favour of a caecostomy, and quote two deaths in a series of 150 cases. On the other hand, Albers and Smith (1952) have studied their hospital records and conclude that the establishment of a transverse colostomy is the safest procedure. Colcock (1951) appears to be quite satisfied with the efficiency of a caecostomy in large bowel obstruction, whilst Lockhart-Mummery (1951) advocates a transverse colostomy. In the course of a discussion on the treatment of acute intestinal obstruction by the Medical Society of London in 1952, Blackburn and Burge both expressed the opinion that there was no place for caecostomy, whilst Aylett and Munro disagreed.

In this communication the technique of caecostomy is described and its advantages are discussed. Cases of acute large bowel obstruction due to carcinoma are not common, which accounts for the small number of patients (11) in this series. In the same period a colostomy was not found necessary for acute large bowel obstruction caused by carcinoma.

Reports of Cases.

CASE I.—Mrs. A., aged forty-five years, was admitted to the Royal Melbourne Hospital with an acute large bowel obstruction, which was found at operation to be caused by a carcinoma of the sigmoid colon. A caecostomy was performed, and thirteen days later a left hemicolectomy with anastomosis of the transverse colon to the rectum. The convalescence was uneventful, and the caecostomy fistula had closed within ten days of the operation.

CASE II.—Mrs. B., aged thirty-two years, after a period of increasing abdominal discomfort for the previous six months was admitted to hospital with acute large bowel obstruction, which was found at laparotomy to be caused by a carcinoma of the splenic flexure. A caecostomy was established, and seven days later a left hemicolectomy with anastomosis of the transverse colon to the rectum was performed. Her convalescence was uncomplicated, and on her discharge home on the eighth day after the operation the caecostomy was dry.

CASE III.—Mr. C., aged seventy-eight years, was admitted to hospital with clinical and radiological evidence of acute large bowel obstruction, apparently due to a carcinoma of the sigmoid colon. At operation the caecum was found per-

forated and there was heavy local contamination; the presence of a large carcinoma of the sigmoid colon was confirmed. A caecostomy was established, and eighteen days later the sigmoid colon was resected. Convalescence was uneventful, and the caecostomy had closed before the patient's discharge from hospital.

CASE IV.—Mr. D., aged sixty-eight years, was admitted to hospital suffering from a carcinoma of the rectum. Soon after his admission he developed an acute large bowel obstruction. A caecostomy was performed through a McBurney incision. The obstruction was relieved, and twelve days later a restorative resection of the rectum was carried out. The caecostomy had closed spontaneously when the patient was discharged from hospital.

CASE V.—Mrs. E., aged sixty-two years, was admitted to hospital with large bowel obstruction, and a plain X-ray examination of the abdomen revealed the cause to be situated towards the hepatic end of the transverse colon. A caecostomy was established, and ten days later a right hemicolectomy was carried out for an annular obstructing carcinoma of the hepatic end of the transverse colon. The caecum was detached from the abdominal wall without difficulty. An end-to-end anastomosis of ileum to transverse colon was followed by an uneventful convalescence.

CASE VI.—Mrs. F., aged sixty-four years, was admitted to hospital with acute large bowel obstruction due to a carcinoma of the recto-sigmoid junction. The tumour was large and apparently fixed. A caecostomy relieved the obstruction and was associated with rapid improvement in the patient's condition. Two weeks later and just prior to the proposed operation for resection of the bowel her condition began to deteriorate, and she died in the fifth week after the caecostomy had been established. An autopsy revealed peritoneal secondary deposits; the obstruction had been relieved adequately.

CASE VII.—Mr. G., aged sixty-three years, was admitted to hospital with an acute large bowel obstruction due to an extensive carcinoma of the upper third of the rectum. A caecostomy was established. Subsequent investigations revealed a large thoracic aortic aneurysm, advanced cerebral degeneration and a strongly positive Wassermann reaction. However, it was decided that an abdomino-perineal resection was in the best interests of the patient. Despite good initial progress he died on the seventeenth post-operative day with a lung abscess.

CASE VIII.—Mr. H., aged seventy-two years, was admitted to hospital almost moribund, with severe abdominal pain and vomiting of eighteen hours' duration. The abdomen was tight and distended. In the rectum was a large, fixed, hard, irregular mass. A laparotomy was performed through an oblique incision in the right iliac fossa, and a ruptured caecum was found complicating a large bowel obstruction; there was extensive contamination of the peritoneal cavity. A caecostomy was established, but the patient died within a few hours.

CASE IX.—Mrs. I., aged eighty-four years, was admitted to hospital with an acute large bowel obstruction of two days' duration. A laparotomy revealed that it was caused by a carcinoma of the splenic flexure. A caecostomy was established, and sixteen days later the tumour was resected. Her convalescence was uneventful. The caecostomy had closed spontaneously by the time of her discharge from hospital.

CASE X.—Mr. J., aged sixty-three years, was admitted to hospital with an acute large bowel obstruction of three days' duration. His abdomen was grossly distended. A laparotomy revealed a carcinoma of the recto-sigmoid zone, and a caecostomy was established. The obstruction was relieved, and fourteen days later the affected portions of the colon and rectum were resected with primary end-to-end anastomosis. The operation was followed by a smooth convalescence, and the caecostomy closed as soon as the tube was removed from the wound.

CASE XI.—Mr. K., aged seventy-three years, was admitted to hospital with an acute large bowel obstruction of four days' duration. His abdomen was very distended, and he appeared to be dehydrated by vomiting. A plain X-ray film of the abdomen indicated an obstruction in the descending colon. A caecostomy was established, and nine days later a left hemicolectomy with anastomosis of the splenic flexure to the recto-sigmoid segment of colon was performed. His convalescence was uneventful, and he returned home, with all wounds dry, on the eleventh post-operative day.

Analysis of Cases.

In six cases (Cases IV, V, VI, VII, VIII and XI) the diagnosis of the cause of the obstruction was possible before operation, and in these a caecostomy was performed without preliminary exploration of the abdomen. In five cases (Cases I, II, III, IX and X) a preliminary laparotomy was necessary. One patient (Case VIII) was admitted to hospital almost moribund, and died within a few hours of the operation. In each of the other cases the obstruction was effectively relieved.

In each of the eight cases (Cases I, II, III, IV, V, IX, X and XI) in which subsequent resection was followed by primary open anastomosis of the bowel, the convalescence was within normal limits. The caecostomy closed spontaneously in each of the seven cases (Cases I, II, III, IV, IX, X and XI) in which it was permitted to do so.

There were three deaths (Cases VI, VII and VIII). In Case VI the patient died from multiple peritoneal secondary deposits after caecostomy had relieved the obstruction. One patient (Case VII), a "poor risk", died after an abdomino-perineal excision performed seventeen days after the caecostomy had relieved the obstruction. In Case VIII the patient was almost dead on his admission to hospital and the caecostomy was established as a desperate measure. In none of these three cases can it be said that caecostomy hastened the end.

Technique of Caecostomy.

Incision.

A muscle-splitting incision is made in the right iliac fossa, and the peritoneum is incised in the same way as precedes the removal of the appendix. If it is necessary to explore the abdomen to confirm the diagnosis, the incision can be extended sufficiently to permit introduction of the hand.

Opening of the Caecum.

A portion of the caecum is withdrawn from the abdomen, and the edges of the peritoneum are sutured with interrupted or continuous sutures to the caecal wall (Figures I and II). If the caecum can be exteriorized sufficiently, a rubber-guarded clamp can be applied to prevent leakage of the bowel contents until the tube is snugly in position. If not, packs and a sucker are arranged around the projecting caecum, and the apex of the bowel is incised; flatus and fluid fæcal material are allowed to escape freely into a dish.

Insertion of Caecostomy Tube.

A soft rubber tube, 1·5 centimetres in diameter, is inserted into the caecum for a distance of three to five centimetres. Plain catgut (size 00) is passed through the edge of the incision in the caecal wall and through the rubber tube, and is tied (Figure III). This serves to prevent the tube from falling out. A Mallecot or de Pezzer self-retaining catheter can be used but is not essential. A purse-string suture is placed around the incision in the caecum, and is tightened and tied after the tube has been invaginated. A second and third purse-string suture are inserted, and each time the tube is further invaginated (Figures IV and V).

No Sutures in Wound.

It is unnecessary to suture the wound or any layer of it unless the initial incision was extended to allow exploration of the abdomen. A muscle-splitting incision comes together unaided. Sutures result in a hæmatoma enclosed in the deeper parts of the wound; they may devitalize tissues; foreign material, dead tissue and blood clot, together with the inevitable contamination associated with caecostomy, will lead to wound sepsis.

Post-operative Care.

A light absorbent dressing is placed over the wound and around the tube. The tube is held in place with "Elastoplast". The tube must not be clipped off to aid transport from the operating theatre to the ward; it is kept open and draining into a dish or bottle. It must be emphasized that the caecostomy tube is to be kept patent continuously from the moment it has been inserted. The safest plan is for the surgeon to accompany the patient back to the ward

and personally supervise the connexion of the caecostomy tube with the bedside bottle. It is equally important that the tube drain freely without obstruction for the first forty-eight hours; the faecal contents may become inspissated within the caecostomy tube, and therefore the tube should be syringed regularly, and certainly within the first six hours after the operation. Much of the bad reputation which accompanies a caecostomy is due to inability to maintain a patent caecostomy tube from the time it is placed in the caecum.

FIGURE I.
The caecum is withdrawn through an oblique incision in the right iliac fossa.

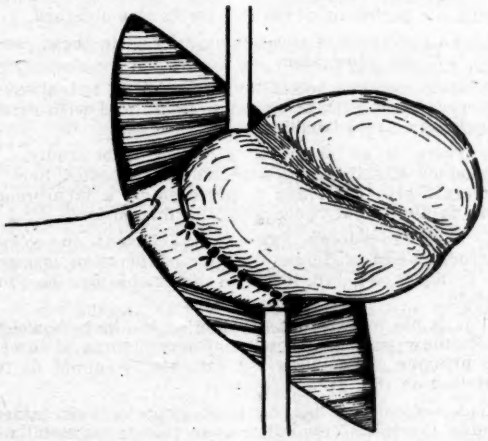

FIGURE II.
The caecum is stitched to the edges of the peritoneal incision.

It is not necessary to give the patient antibiotics or chemotherapy. The contamination of the wound will lead to infection only if conditions are favourable; by the avoidance of wound sutures infection is discouraged. The usual ancillary aids for counteracting intestinal obstruction — namely, intestinal intubation and intravenous therapy—are instituted on the patient's admission to hospital.

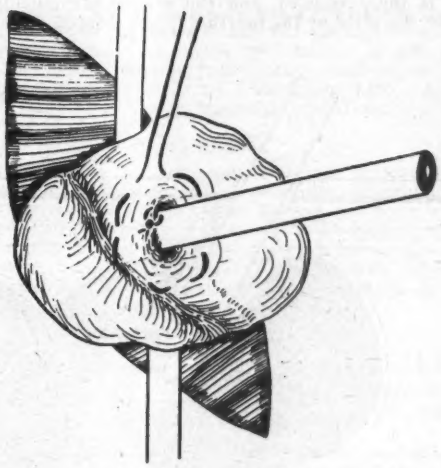

FIGURE III.
The tube is inserted through an incision in the apex of the caecum, and anchored by a plain catgut suture passing through caecum and tube. A purse-string suture is inserted, and the tube is inverted as the suture is tied.

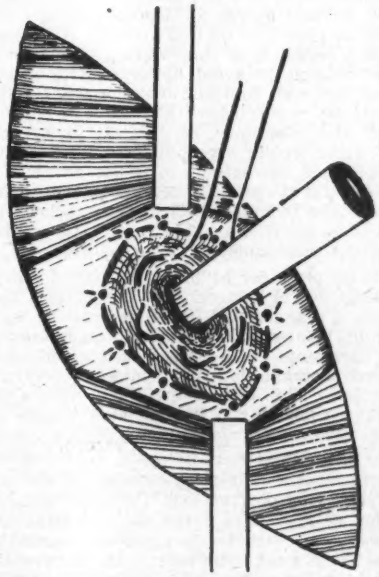

FIGURE IV.
Further purse-string sutures are placed in position with further inversion of tube and caecal wall, resulting in the replacement of caecum within the abdominal cavity.

In most instances the patient will open his bowels in the normal manner after five or six days, and it then becomes possible to give rectal enemata and wash-outs in preparation for the resection of the colon. The administration of phthalyl-sulphathiazole (May and Baker) is com-

menced five days before the resection, and the presence of a caecostomy allows at least part of it to enter the large bowel after oral ingestion.

The caecostomy tube is left *in situ* until the bowels have started to function again after the bowel resection. The tube is then removed, and the caecostomy quickly dries and by the third or the fourth day has stopped discharging.

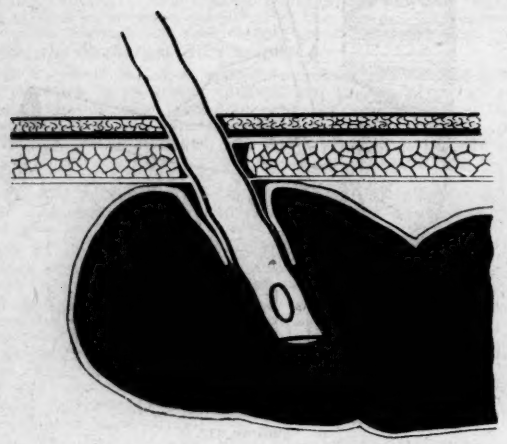

FIGURE V.
A cross-section to show how the tube lies in the caecum.

Discussion.

The establishment of a caecostomy is not always an easy procedure; for that matter a colostomy can also be difficult. If the caecum possesses limited mobility it may be hard to exteriorize a segment, so that when the caecum is opened it may be difficult to avoid undue contamination. After the patient has been returned to the ward, the caecostomy tube should be connected with a bedside bottle, and the patency of the tube must be ensured by syringing with saline or water within six hours of the operation and at regular intervals thereafter, until the abdomen has been deflated. Careful attention to detail will enable the surgeon to overcome the technical difficulties attached to the performance of a caecostomy; his reward for achieving this is a resection unencumbered by a colostomy.

There is no place for a "blind" caecostomy in the treatment of large bowel obstruction. If a patient has a bowel obstruction, a diagnosis of its cause must be made, and if necessary by laparotomy. A "blind" caecostomy implies a *"blind" operation with the danger of overlooking* unsuspected strangulation—for example, a volvulus of the sigmoid colon. This is no more likely with a caecostomy than with a colostomy. The incision in the right iliac fossa can always be made large enough to allow the abdomen to be explored if the need should arise.

It has been said that a caecostomy is not an efficient means of relieving obstruction. Certainly some distension lingers for several days after the caecostomy has been established; but this is seen equally commonly after colostomy. It is most important in the early post-operative period to keep the caecostomy tube patent, for there is a tendency for it to become blocked. A caecostomy has not once failed in my experience to relieve obstruction and deflate the large bowel.

One of the most common arguments raised against caecostomy is the inability of such an opening to defunction the distal portion of the colon. When colonic surgery was performed without the aid of chemotherapy and antibiotics, the construction of a preliminary colostomy with the intention of defunctioning the distal portion of the colon was regarded by some as the safest procedure. Even so, in some centres the one-stage resection with primary anastomosis has been the procedure of choice for years, and with excellent results. It is quite unnecessary to perform colonic resection and anastomosis on a defunctioned bowel only, and it is unfair to criticize the caecostomy because it will not defunction the colon. If the surgeon is certain that the blood supply of the bowel to be anastomosed is adequate, and if he can perform the operation without any tension on the suture line and possesses a flawless technique, trouble follows but rarely.

A caecostomy has a most important advantage over transverse colostomy, in that mobilization of the transverse colon is facilitated if the surgeon elects to perform a left hemicolectomy. The uppermost limit of resection of the lymph field in carcinoma of the left side of the colon is the origin of the inferior mesenteric artery from the aorta, just under the third part of the duodenum. If the tumour is in the upper part of the descending colon, it may prove necessary to mobilize even the hepatic flexure. If the tumour is at the splenic flexure, it may be desirable to sacrifice both middle colic and inferior mesenteric arteries, and in the circumstances a transverse colostomy makes restoration of the colonic canal a difficult task. It is not uncommon to find that the surgeon at the first laparotomy believes the tumour to be in the descending colon, and yet to his surprise finds at the second operation that the tumour is really in the splenic flexure end of the transverse colon. A caecostomy functions just as efficiently for a carcinoma of the sigmoid colon as it does for a tumour of the splenic flexure, so that it is unnecessary to be selective in choice between colostomy and caecostomy merely on the situation of the tumour.

A small advantage of the caecostomy over colostomy lies in the spontaneous closure of the faecal fistula which is the rule after removal of the caecostomy tube; if the caecum is withdrawn and left outside the abdomen in the same way as is done with the colon in colostomy, a formal closure will be required.

Summary.

1. *The histories of 11 cases in which a caecostomy was* established are presented. In each case the patient was suffering from acute large bowel obstruction due to a carcinoma of the colon or rectum. The series is continuous and unselected, and in no case was a colostomy established during the period in which this series was obtained.

2. The technique of caecostomy as used in these cases is described and illustrated.

3. Although the caecostomy operation is not always an easy procedure, with attention to detail and with care the surgeon can avoid troubles.

4. There is no place for a "blind" caecostomy. The *method of establishing a caecostomy advocated here is a* deliberate procedure, and is preceded by a laparotomy if there is any doubt concerning the diagnosis.

5. The caecostomy has proved efficient in relieving obstruction and producing deflation of the colon; symptoms are promptly relieved, although distension may be slow to subside.

6. *It is not necessary to defunction the large bowel with* a colostomy prior to resection of a carcinoma of the colon and primary anastomosis. A caecostomy cannot be fairly criticized on this ground.

7. A caecostomy has its most important advantage in *leaving the transverse colon quite free to be mobilized in* the event of an extensive resection of the colon. A transverse colostomy may embarrass the surgeon in this regard.

8. A "tube" caecostomy closes spontaneously when the tube is removed. A colostomy nearly always requires formal closure.

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DIAGNOSIS AND MANAGEMENT OF CHRONIC PYELONEPHRITIS.

By DONALD G. DUFFY and DOUGLAS B. DUFFY,
Melbourne.

ACUTE INFECTIONS of the renal tract seldom offer much difficulty in diagnosis, yet the gradation in severity of the inflammatory reaction is such that in many cases of a mild character medical attention is never sought. In others, the symptoms of frequent micturition and dysuria are referable to the lower part of the urinary tract and may not indicate a primary renal infection as the cause.

Cases in which at the outset the presenting symptoms are fever, rigors, loin pain and tenderness leave no room for doubt that the site of the infective process is in the kidney, giving rise to acute pyelonephritis.

This most common of renal diseases may affect one or both kidneys. Unilateral disease suggests the association with some anatomical abnormality or obstruction to urinary outflow on the affected side, whereas bilateral involvement is typical of blood-borne infection and obstructions at or below the bladder neck.

Many patients with acute pyelonephritis unassociated with surgical conditions of the urinary tract must recover completely, but a number proceed through persistent or recurrent infection to a chronic state.

The tendency of pyelonephritis to relapse is well known, and with each relapse further renal damage will occur. It is impossible to state with any claim to accuracy what proportion of cases of acute pyelonephritis enters a chronic state, because of the obvious difficulty of recognizing all acute cases.

The condition of chronic pyelonephritis is itself difficult to diagnose on clinical grounds, while histological recognition may be so complicated by the ischæmic lesions of chronic vascular disease and hypertension that the whole process may be mistakenly attributed to vascular disease alone.

The criteria of histological diagnosis of chronic pyelonephritis were clearly set out by Weiss and Parker (1939), and have been adopted in the main by subsequent writers, while the importance of chronic pyelonephritis as a cause of renal failure has long been recognized (Longcope, 1937; Weiss and Parker, 1939; Platt and Davson, 1950; Enticknap and Joiner, 1953).

It is the purpose of this paper to discuss the diagnosis of chronic pyelonephritis, and to make some remarks on the procedures of investigation and treatment.

History.

Owing to the mildness of early symptoms, specific inquiry should be made as to the occurrence of past attacks of loin pain, renal colic, frequency of micturition, dysuria or hæmaturia. Although the incomplete information received may not always be sufficient to exclude a nephritic episode, in general there is a failure to describe in such attacks the cardinal features of one of the forms of nephritis. In this regard the absence of œdema is significant, since œdema rarely occurs in pyelonephritis except when associated with cardiac failure.

The late, insidious onset of renal failure is marked by lassitude, easy fatigue, gradual weight loss, dryness of the skin and gastro-intestinal disturbances, at which stage the underlying cause may be almost impossible to define on clinical grounds. The daily urinary output is large, and the degree of nocturia is an indication of the state of renal function, except when bladder-neck obstruction is present.

Albuminuria.

Albuminuria may be found at any time during the protracted course of the disease, but the amount of albumin excreted is usually not large (0·1 to 1·5 grammes *per diem*) and may appear intermittently. Cast formation is correspondingly infrequent by comparison with nephritis, and casts are often absent from the centrifuged deposit.

Hæmaturia.

Macroscopically evident hæmaturia may appear during an attack of acute pyelonephritis or at any subsequent time during the chronic course of the disease, although hæmaturia is usually microscopic in degree. Hæmaturia may be a remarkably persistent feature in some cases, suggesting progressive renal destruction; yet pyelograms may fail to demonstrate any gross changes in pelvic or calyceal outline.

Pyuria.

Pyuria is a feature of acute attacks and of subsequent exacerbations, the urine being free of pus cells between these bouts. In chronic cases it may be necessary to examine the urine on a number of occasions, in order to demonstrate intermittent pyuria.

Sternheimer and Malbin (1951) found by special staining that the leucocytes in pyelonephritis show changes peculiar to this disease. The writers have had no experience of the results of this technique.

Pathogenic organisms can be grown on culture during the acute exacerbations, and the importance of attempting culture prior to commencing treatment will be discussed later.

Chronic Renal Failure.

The association of chronic pyelonephritis with long-standing elevation of the blood urea level has been observed for many years. Longcope and Winkenwerder (1933) remarked the extent to which renal insufficiency may advance without noticeable impairment of the health of the subject. They recorded the case of a youth, aged nineteen years, actively engaged in athletics, who had a blood urea content of 130 milligrammes per 100 millilitres. The following case is somewhat similar in this respect.

A male patient was aged twenty years in 1941, when routine urine tests revealed inconstant albuminuria. Over the next four years he had four attacks of urinary tract infection. Persistent albuminuria in 1945 was responsible for a diagnosis of "nephritis". His blood pressure was 155 millimetres of mercury, systolic, and 100 millimetres, diastolic. The fasting blood urea content was 30 milligrammes per 100 millilitres. Microscopic examination of the urine revealed no abnormality. Attempted culture of microorganisms from the urine produced no growth. In 1950 he complained of frequent headache, and his blood pressure was 160 millimetres of mercury, systolic, and 110 millimetres, diastolic. The fasting blood urea content was 48 milligrammes per 100 millilitres. The concentration of urea in the urine was below 2%. Intravenous pyelography revealed a normal kidney on the left side and a rudimentary but functioning kidney on the right side. Retrograde pyelography gave normal findings on both sides. In 1951 the headache was still troublesome; the blood pressure was 195 millimetres of mercury, systolic, and 140 millimetres, diastolic. The urine contained a heavy cloud of albumin, and five polymorphonuclear leucocytes per high-power field. In 1952 the patient was a little short of breath on effort. His blood pressure was 200 millimetres of mercury, systolic, and 140 millimetres, diastolic. The fasting blood urea content was 100 milligrammes per 100 millilitres. In May, 1953, he was feeling well and playing football in a local team. His blood pressure was 220 millimetres of mercury, systolic, and 140 millimetres, diastolic. His fasting blood urea content was 117 milligrammes per 100 millilitres. In August, 1953, he had a recurrence of headache and loss of energy. The blood pressure was 220 millimetres of mercury, systolic, and 150 millimetres, diastolic. Exudate was present in the left *fundus oculi*. The urine contained much albumin ("+++") and 200 red cells per high-power field. The fasting blood urea content was 156 milligrammes per 100 millilitres. In November, 1953, the patient suffered from sudden cardiac

failure with a drop in the blood pressure to 170 millimetres of mercury, systolic, and 100 millimetres, diastolic. The fasting blood urea content was then 344 milligrammes per 100 millilitres. Death occurred in the patient's thirty-third year. At autopsy the right kidney weighed half an ounce and the left kidney four ounces. Histological examination revealed chronic pyelonephritis on the right side.

In retrospect, it was unfortunate that the retrograde pyelogram was misinterpreted and consideration of nephrectomy on the right side deferred despite the evidence of unilateral disease as shown by intravenous pyelography.

This state of physical well-being in the presence of considerable nitrogen retention and often severe hypertension is distinct from the debility of chronic nephritis, which usually appears before either blood pressure or blood urea content has reached a level in any way comparable with that found in chronic pyelonephritis.

At any stage, as the result of intercurrent infection or surgical intervention, the patient with chronic renal failure of this type may be precipitated into clinical uræmia, with pronounced gastro-intestinal upset, great weakness, headache and a sharp rise in the blood urea level.

The factors of increased protein catabolism and a temporary decline in renal function are no doubt important in the production of this state of metabolic breakdown. The process is reversible to some extent, the blood urea level falling again as recovery from infection occurs.

Anæmia.

Iron deficiency anæmia is associated with all forms of chronic renal disease, and is generally refractory to the oral administration of iron. Blood transfusion is worth while in the presence of very low hæmoglobin levels, while the intravenous use of saccharated iron ("Ferrivenin") may help to maintain the hæmoglobin at a more satisfactory level. It is the debility associated with an anæmic state which often brings these patients under medical observation for the first time. The possibility of underlying chronic renal disease should be amongst the first considerations when microcytic anæmia fails to respond to the oral administration of adequate doses of iron. Roscoe (1952) has shown how hæmoglobin levels are quantitatively related to the blood urea level, the former falling as the latter increases, and despite transfusion and intravenous iron therapy the hæmoglobin level falls slowly to nine or ten grammes *per centum* and remains there.

Hypertension.

Since Weiss and Parker (1939) recognized the importance of chronic pyelonephritis as a cause of renal failure and hypertension, speculation has sought to express the frequency with which these complications follow acute and chronic urinary tract infections. The answer is still to be found; but later reports (Platt and Davson, 1950; Pickering and Heptingstall, 1953) have repeatedly emphasized the definite causal relationship which links chronic pyelonephritis with the development of hypertension.

It is of interest that Saphir and Taylor (1952), in reviewing 50 cases of "malignant hypertension" according to the histological criteria of Weiss and Parker, reclassified 43 as cases of severe diffuse chronic pyelonephritis. Platt and Davson (1950) rightly deplored the indiscriminate use of the term "malignant hypertension", which should denote the malignant phase of essential hypertension as distinct from hypertension associated with primary renal disease. It would probably be better if a new name was devised for the state of malignant (essential) hypertension, because uncritical application of this term to any state of progressive hypertension will result in a failure to recognize primary renal disease at a stage when it may be relieved by early medical or surgical treatment. As Platt and Davson also point out, malignant (essential) hypertension is rare at any age when cases of primary renal disease are excluded, and especially is this so in young individuals.

Hypertension, when it is associated with chronic pyelonephritis, may produce high levels of systolic and diastolic blood pressure for years without the appearance of serious fundal changes, such as papilloedema, retinal hæmorrhages or exudates. It therefore follows that young subjects with established hypertensive states should always be considered from the standpoint of chronic urinary tract infection and have the appropriate investigations performed.

Investigations.

Special investigations are frequently neglected because of the rapid amelioration of symptoms with easily administered antibiotics. This may engender misplaced confidence that a cure has been effected. Repeated cultural examination of the urine will result in the discovery of the infecting organism when pyuria is present, and occasionally constant bacilluria may be found in the absence of pyuria. It is unsafe to assume that such organisms necessarily come from the upper part of the urinary tract unless they are again recovered on ureteric catheterization, because acute or chronic cystitis, with the infection completely localized to the bladder, is not uncommon.

The method of collection of urine specimens is important, a catheter specimen being necessary in females, because specimens that have been passed are most unreliable. In the male a mid-stream specimen is usually sufficient; a culture is prepared from the urine and the organisms so obtained are tested for sensitivity to the various antibiotics. Culture of tubercle bacilli from a twenty-four hour specimen should be attempted in many cases, owing to the occasional association of tuberculous pyelonephritis with infection due to other organisms.

The somewhat tedious performance of Addis cell counts may give additional information to confirm the chronicity of the infective process, but in general adds little to the clinical assessment of the case.

Renal function tests show impairment in the later stages of the disease when a persistently elevated blood urea level is characteristic. The urea concentration test often shows that large volumes are excreted in each specimen, and that there is a concentration of urea in the urine below 2% in all specimens, the total amount of urea excreted in three hours being below five grammes *per centum*. The results of clearance tests are sometimes misleading if taken at their face value, owing to the effect of large urinary output in the equation $Cm = \frac{UV}{B}$, where Cm = maximum clearance, U = milligrammes of urea nitrogen per 100 millilitres of urine, B = milligrammes of urea nitrogen per 100 millilitres of blood, and V = millilitres of urine per minute.

Cystoscopy and pyelography (both intravenous and retrograde if necessary) are then carried out in order to determine whether there are any obvious underlying causes for the infection. Obstructive lesions at the pelvi-ureteric junction, in the lower parts of the ureters or in the bladder neck may be demonstrated. Bladder tumours, which occasionally present with the characteristics of a urinary infection, are excluded and ureteric specimens are obtained for cultural examination. If any obvious cause for the infection is found, the treatment of this cause, together with treatment of the infection, will usually be effective in producing a cure. However, in the majority of cases no cause within the urinary tract can be found and no infective focus outside the urinary tract can be demonstrated.

The pyelographic appearances in these cases may be perfectly normal, may indicate minor distortions of the calyceal pattern, or may simply show impaired function on one or both sides. The pyelograms occasionally show mild generalized dilatation of the pelves and minor calyces, sometimes the calyces present a rather "stiff" or "rigid" appearance, and at other times calyectasis with constriction of the outlet from the minor calyces is evident.

Treatment.

The correct treatment of chronic pyelonephritis necessitates at the outset the culture of the infecting organism and an estimation of its sensitivity to antibiotics. It is also important to exclude the possibility of urinary tract

obstruction, since the presence of such complications may affect the choice of antibiotic treatment. The aim of treatment both in acute attacks and in exacerbations of chronic disease should be the eradication of infection and subsequent investigation to disclose any predisposing factors to recurrence.

Discussion of treatment must necessarily deal with the management of acute pyelonephritis, for it is only by thorough treatment of the early infection that the later sequelæ may be avoided. Too many patients presenting in their first acute attack are rendered symptomless by inadequate treatment, only to have a subsequent relapse. Too few are later subjected to examination of the urinary tract, to exclude congenital abnormalities, calculi or surgically curable obstruction.

The frequency with which different organisms infect the urinary tract is variable; but approximately 80% to 85% of infections are due to Gram-negative bacilli and 15% to 20% are due to Gram-positive cocci—staphylococci and streptococci. Of the Gram-negative bacilli, *Escherichia coli* is the commonest, followed by *Pseudomonas pyocyanea*, *Aerobacter aerogenes*, *Escherichia intermedium*, Proteus, Alcaligenes and the paracolon bacillus. Some of these are differentiated only by special bacteriological tests.

Since *E. coli* is the common pathogen, empirical therapy with alkaline mixtures or one of the sulphonamides is often successful in relieving the patient of his symptoms, if not the disease. As was mentioned above, most of the symptoms are referable to the lower part of the urinary tract and do not necessarily reflect the state of affairs higher up, where resolution may be incomplete at the time when treatment is arrested because of symptomatic relief or the completion of some arbitrary dose schedule. Moreover, it is important to remember that the drug used must reach an adequate concentration in the extracellular fluid of the kidney, and that this may be quite different from the concentration which the drug may subsequently attain in the urine. With this in mind, certain deficiencies will be seen to occur in the use of compounds such as "Mandelamine", which does not achieve any effective concentration in renal tissue, but which, on the other hand, may be useful in lower urinary tract infections.

The main standby in treatment is the sulphonamide group of drugs, whether used alone or in combination with other antibiotics. These are effective in most *E. coli* infections and to a varying degree when used in the treatment of infections due to other pathogenic organisms except *P. pyocyanea*. The main disadvantages pertaining to their general use are individual sensitivity and the occasional occurrence of a sulphonamide-resistant organism. Those preparations recommended on the grounds of freedom from side effects include sulphadimidine and "Gantrisin". The urine should be made alkaline during their administration, and treatment should continue for at least a week in the case of acute infections. Culture from the urine should be attempted on two occasions during the subsequent week to confirm the disappearance of the pathogenic organism. In cases of chronic pyelonephritis the use of the sulphonamide preparation should be continued for three weeks, and another attempt at culture from the urine should be made after cessation of treatment.

Penicillin, while ineffective against infections due to *E. coli*, Proteus, *P. pyocanea* and *S. fæcalis*, has a place in the treatment of staphylococcal and streptococcal infections, and may be more effective when used in conjunction with streptomycin.

Streptomycin is a valuable adjunct to the treatment of urinary tract infection, but should not be used in the presence of obstruction to urinary outflow, owing to the rapid development of drug resistance in this circumstance. It should be used in doses of two grammes per day for four to five days only, the urine being rendered alkaline to increase the antibacterial effect of the drug.

"Aureomycin", "Chloromycetin" and "Terramycin" are all of value in selected cases in which resistance has developed to other antibiotics. It should be noted that none of these drugs is bactericidal in action, and consequently even when the pathogenic organism is apparently sensitive to one or the other, it is advisable to use sulphadimidine or streptomycin in conjunction with it.

The obvious necessity to choose the appropriate antibiotic with which the commence treatment is matched by the equal necessity to demonstrate its effectiveness in eradicating the invading organism by urine culture subsequent to the cessation of therapy. Only if this is done can the risk of recurrence and the incidence of late sequelæ be mitigated.

Management of Sequelæ.

Chronic Renal Failure.—In the management of a patient with slow but progressive renal failure, treatment of any active infection may result in temporary improvement. The protein content of the diet should be reduced to between 40 and 60 grammes *per diem* in order to restrict urea production, while a salt content of two grammes or less is desirable, especially for patients with hypertension. No restriction should be placed upon fluid consumption; in fact, the patient should be encouraged to maintain an intake of four pints or more *per diem* to ensure a large volume of urine.

Anæmia.—The oral administration of iron compounds may be commenced, but if this is found to be ineffective in maintaining a satisfactory hæmoglobin value, intravenous dosage can be tried. Should this also prove unsatisfactory, transfusion of whole blood or preferably packed red cells will result in general well-being as well as in improvement in the hæmoglobin level.

Cobalt nitrate is said to promote hæmoglobin formation in anæmia associated with uræmic states. Some such response was obtained in two cases in which this was tried, although gastro-intestinal disturbance caused cessation of therapy in one case after an initial improvement in the hæmoglobin value.

Hypertension.—The practice followed in the treatment of patients with hypertension has been to achieve symptomatic relief, generally without recourse to hypotensive drugs, or in those with gross but chronic arterial changes, without depressing the blood pressure to anything like normotensive levels. Should severe headaches persist in spite of treatment, or a progressive tendency be noted in the hypertensive state, hypotensive drugs are used to afford relief and to reduce the diastolic pressure. "Vegolysen" was administered orally in seven cases of chronic pyelonephritis with nitrogen retention. It was found that sometimes extremely small doses were required to produce symptomatic relief and the arrest of ocular damage. The postural hypotensive effect was produced with doses as low as half a tablet three times a day. No deterioration of renal function was observed to follow the use of "Vegolysen" in these cases. More recently "Serposil" alone or combined with "Apresoline" has been preferred. Lumbo-dorsal sympathectomy was not advised for any patient diagnosed as suffering from chronic pyelonephritis, although seven patients previously diagnosed as suffering from "malignant hypertension" had had lumbo-dorsal sympathectomy performed prior to their observation by us. The result in these seven cases was satisfactory. It is possible that selected patients with chronic pyelonephritis and hypertension showing acceleration of their vascular lesions may be benefited considerably by this operation, provided established cardiac failure and obvious impairment of renal function are not present when it is performed.

Muscle Spasm.—Cramping pains in limbs and elsewhere are often a constant source of annoyance; they may be associated with some decrease in alkali reserve and lowered serum calcium levels. In such cases relief may be provided by the use of calciferol, 50,000 units daily, and calcium gluconate, 30 grains three times a day.

Cardiac Failure.—The management of cardiac failure in association with chronic pyelonephritis requires no departure from standard therapy with digitalis and mercurial diuretics. There is a reluctance in some quarters to use mercurial diuretics in the presence of chronic renal disease,

although there is little indication that when given intramuscularly they have any undesirable effect on the kidney. There is always the risk of sensitivity to mercury compounds, which prevails whether in a case of renal disease or otherwise, but which certainly seems to be no greater in the former instance.

Summary.

1. The diagnosis of chronic pyelonephritis is often difficult to confirm, although the condition is presumed to be the cause of intermittent albuminuria, hæmaturia and pyuria. Thorough urological investigation should be undertaken in such cases, especially when the condition occurs in young adults, and before the onset of chronic renal failure.

2. In both acute and chronic cases treatment should commence as early as possible and continue long enough to ensure eradication of the infection.

3. The advent of complications such as severe hypertension and anæmia may disguise the nature of the underlying renal disease. The treatment of such complications involves the use of standard measures, although caution should be exercised in the use of hexamethonium compounds in the presence of impaired renal function.

Acknowledgement.

Dr. G. C. de Gruchy kindly supplied the cobalt nitrate tablets which were used in the two cases mentioned above.

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THOMAS JAMISON AND THE BEGINNING OF MEDICAL JOURNALISM IN AUSTRALIA.

By EDWARD FORD,
Sydney.

ONE hundred and fifty years ago, on October 14, 1804, Australian medical publication commenced with the appearance of a short article in *The Sydney Gazette*, the official newspaper of the sixteen-year-old colony of New South Wales. This first contribution, "General Observations on the Small Pox", was written by Thomas Jamison, M.D., R.N., the Principal Colonial Surgeon. A number of publications dealing, at least in part, with medical subjects connected with the colony had already appeared, but these were all printed in England. The most notable of them is the excellent "Journal of a Voyage to New South Wales", by John White, the first Principal Surgeon of New South Wales, which was published in London in 1790. In 1795 an account of the therapeutic properties of the gum of the grass tree appeared in "Essays and Observations, Physiological and Medical, on the Submersion of Animals, and on the Resin of Acoroides Resinifera, or Yellow Resin from Botany Bay . . .", by Charles Kite, which was also issued in London. References of medical interest also occur in many of the accounts of the early settlement, including those of Phillip, Tench, Hunter and Collins. The contribution of Thomas Jamison, however, is the first local medical publication, and marks the initiation of Australian medical journalism.

Jamison's paper was published about five months after the introduction of vaccination to New South Wales, and contains an appeal for its general adoption and a warning of the extreme danger of smallpox. Jenner's discovery of vaccination was announced in his "Inquiry" in 1798, about ten years after the foundation of the first settlement at Port Jackson. The colonial medical staff shared the early and widespread interest in the new method, which was a subject of correspondence with the Home authorities. In

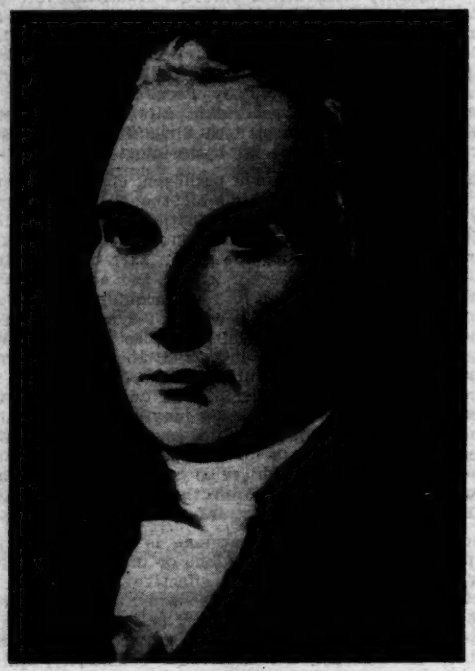


FIGURE I.
Thomas Jamison, M.D., R.N.

1803 Governor King, on Jamison's advice, requested of the Secretary of State for the Colonies that vaccine should be made available to the colony, intimating in his letter that the teats of the local cows had been examined for cowpox without success. "A Pacquet of the Vaccine Matter for Inoculation", prepared by the Royal Jennerian Society, reached Sydney in May, 1804, together with a further batch, from another source, addressed to Assistant Surgeon John Savage. Three children were at once vaccinated by Jamison, Savage and John Harris, Surgeon of the New South Wales Corps, and it was shortly announced that the cowpox was "now fully established in the colony, [and] it is hoped no parent or a guardian of any children will omit availing themselves of so great a blessing". A large number of the children were vaccinated in the next few months, but, as in later days, a proportion of parents neglected their responsibilities and were subjected to official warnings and persuasions that were continued into the present century.

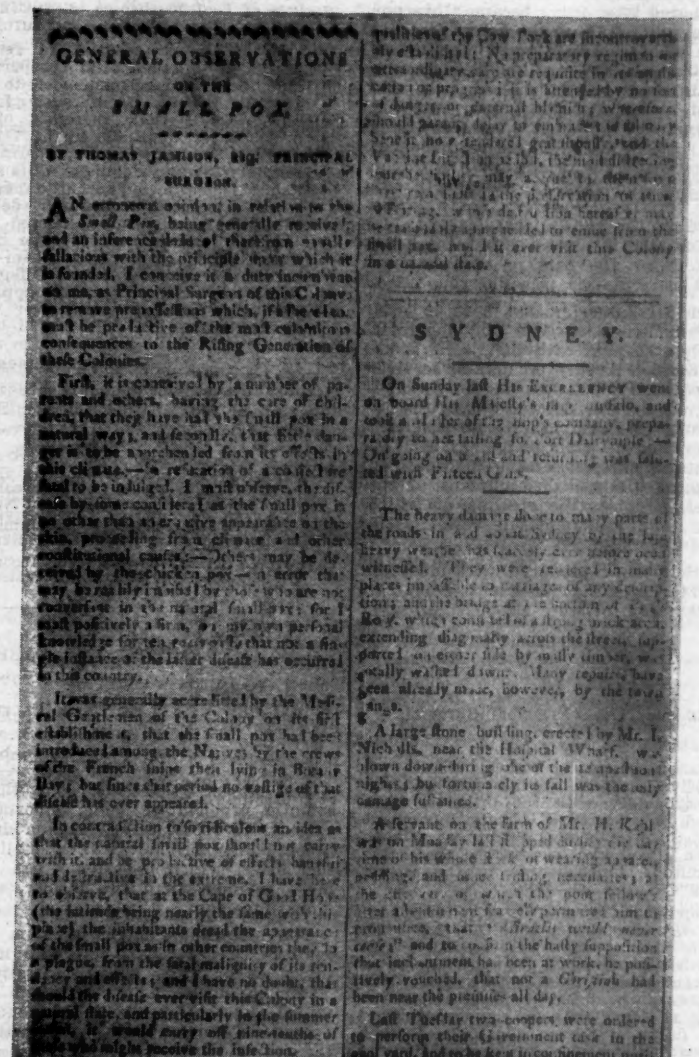
The severe warning issued in the Principal Surgeon's article was intensified by the fact that smallpox had already appeared in New South Wales in 1789, the year after the establishment of the colony. This epidemic, which is mentioned in his paper, caused a heavy mortality

in the aborigines about Port Jackson and spread widely among them. The settlement escaped with a single death, that of a coloured seaman on the *Supply*, and for a long time there was grave apprehension among the doctors for the safety of the unprotected inhabitants. Though it "was generally accreditted by the Medical Gentlemen of the Colony . . . that the small pox had been introduced among the Natives by the crews of the French ships then lying in Botany Bay", this was not substantiated, and its source of introduction remains obscure (Cumpston, 1914).

In his paper the author refers to the severity of "natural" smallpox, or smallpox "in a natural state", implying a differentiation, well recognized at the time, from artificially induced smallpox infection. The latter, under the name of inoculation, was used as a means of smallpox immunization before the adoption of vaccination. The method was brought to England from the East in 1714, and remained in limited use until its prohibition in 1840. Immunity was procured by infecting a scratch or incision with material from the early lesions of a subject of smallpox. The resulting attack was usually mild, though a mortality of up to 6% occurred. Jamison notes that, with vaccination, "no preparatory regimen or extraordinary care are requisite", for in inoculation a preliminary course of treatment was considered necessary, and careful isolation was essential. According to Tench (1793), the surgeons of the First Fleet were provided with "variolous matter in bottles", presumably for inoculation, though it is not known whether the method was ever used in Australia.

Thomas Jamison graduated at Trinity College, Dublin, and joined the Royal Navy, as surgeon's mate, in 1780. In 1788 he arrived in Australia as surgeon's first mate in the *Sirius*, the flagship of Phillip's First Fleet, and was one of the fleet surgeons appointed to remain in the newly founded colony under John White, the Principal Surgeon. Within a month of his arrival at Port Jackson he was posted as medical officer to a detachment, under Lieutenant Philip Gidley King (later third Governor of New South Wales), which was sent by Governor Phillip to found a subsidiary settlement at Norfolk Island. Jamison established a hospital on the island, and remained a medical officer for over ten years.

In 1799 Jamison returned to Sydney as assistant surgeon, and soon after went to England on leave. On his return, he embarked on the convict ship *Atlas*, which had on board as a prisoner Sir Henry Brown Hayes, an Irish baronet, who was transported for the abduction of a young heiress. This turbulent and picturesque character was to remain in Australia for twelve years, during which he was a centre of disaffection and a constant trouble to the colonial authorities. By paying the captain 300 or 400 guineas, Hayes was allotted the best accommodation on the ship and treated as a special guest, while the quiet-mannered Jamison was dealt with in a casual and neglectful way. His protests led to a violent quarrel with the irascible knight, who was exempted from all discipline. This caused Jamison to leave the ship at Rio and to continue his voyage on another vessel. On their arrival in Sydney both Hayes and the captain were brought to trial, and Hayes was given six months in gaol. But this did not end Jamison's trouble, for in May, 1803, Hayes wrote a scurrilous letter about him to the Colonial Office authorities, and also appealed to the Deputy Judge Advo-



GENERAL OBSERVATIONS
ON THE
SMALL POX.

BY THOMAS JAMISON, ESQ. PRINCIPAL SURGEON.

AN enquiry entirely in relation to the *Small Pox*, being generally received; and an inference deduced of that from every fallacious with the principle upon which it is founded, I conceive it a duty incumbent on me, as Principal Surgeon of this Colony, to make public all such which, if believed, must be productive of the most calamitous consequences to the Rising Generation of this Colony.

First, it is conceived by a number of parents and others, having the care of children, that they have had the Small pox in a natural way, and consequently that the disease is to be apprehended from its effects in this climate.—A reflection of a most serious kind to be indulged. I shall observe, that diseases by some considered as the Small pox in no other than a negative appearance on the skin, proceeding from climate and other constitutional causes.—Others may be deceived by the chicken pox—a error that may be easily avoided by those who are not conversant in the natural Small pox: for I shall positively affirm, on my own personal knowledge for ten years past, that not a single instance of the latter disease has occurred in this country.

It was generally accredited by the Medical Gentlemen of this Colony on its first establishment, that the Small pox had been introduced among the Natives by the crews of the French ships then lying in Botany Bay; but from that period no vestige of that disease has ever appeared.

In contradiction to this delusive an idea as that the natural Small pox should not carry with it, and be productive of effects harmful and destructive in the extreme. I have but to observe, that at the Cape of Good Hope (the latitude being nearly the same with this place) the inhabitants dread the appearance of the Small pox as in other countries they do a plague, from the fatal malignity of its rendency and effects; and I have no doubt, that should the disease ever visit this Colony in a general state, and particularly in the summer season, it would carry off nine-tenths of those who might receive the infection.

From the foregoing facts and circumstances, I would most fervently recommend Parents to avail themselves of the blessing held out to them by the provident care of the Parent Country, by having their Children inoculated with the *Variolæ ovinæ* or Cow Pox—an infallible Preventative of the loathsome, disfiguring, and too often fatal disease, when taken in the natural way.

It is almost needless to remark further on the particular virtues and properties of a discovery, announced and recommended to public notice, for the general benefit, from such high and indisputable authority: I shall therefore only remark, that the preventative

SYDNEY.

On Sunday last His EXCELLENCY went on board His Majesty's ship Investigator, and took a sail for the ship's company, preparatory to her sailing for Port Dalrymple.—On going off she fired returning was fired with Fifteen Guns.

The heavy damage done to many parts of the roads in and about Sydney by the late heavy weather has lately been more observable. They were rendered in many places impassable to carriages of any description; and the bridge at the bottom of [illegible] Row, which consisted of a long brick arch, extending diagonally across the stream, together with a causeway on each side by sandy timber, was totally washed away. Many repairs have been already made, however, by the town gang.

A large stone building, erected by Mr. [illegible] Nicholls, near the Hospital Wharf, was blown down during one of the late tempestuous nights, but fortunately to fall was the only damage sustained.

A servant on the farm of Mr. H. Kable was on Monday last [illegible] and during one of his usual fits of wearing away, pelting, and [illegible] accusations, he [illegible] the poor fellow's throat with a razor, [illegible] immediately [illegible] that "*Terrible would never serve*" and to [illegible] the hasty supposition that instrument had been at work, he [illegible] vouched, that not a *Christian* had been near the premises all day.

Last Tuesday two coopers were ordered to perform their Government task in the gaol yard, and to be kept in confinement until completed, owing to their own criminal neglect.

A turnip was some days since taken out of a garden in the vicinity of Parramatta, the diameter of which measured fourteen inches, the circumference above three feet and a half.

The above instance [illegible] from the productions of the Colony [illegible] it may not be doubted, that [illegible] attention to the culture and [illegible] the benefits derived from it to [illegible] countries may be no less [illegible] growth in this.

FIGURE II.
Jamison's first Australian medical publication, from *The Sydney Gazette*, October 14, 1804. (By courtesy of the Mitchell Library.)

cate for protection, claiming that his life was in danger from Governor King and Jamison.

In 1802 Jamison became one of the chief magistrates of New South Wales, and he later also held the position of Naval Officer at Sydney. He appears to have been well regarded in the colony, though his tenure of office as Principal Surgeon was marked by constant strife and worry. This was accentuated after Bligh became Governor in 1806, when differences arose between the administration and the medical service which led to a great hostility in Jamison and his staff towards the new regime. In the trouble that followed Jamison was dismissed from his post of magistrate, and would also have been removed from the position of Principal Surgeon if a suitable officer had been available to replace him. These disturbances culminated in the association of the medical staff with the deposition of Bligh in 1808, and Jamison, Wentworth and Mileham, together with Harris of the New South Wales Corps, were all involved in the subsequent disgrace. In 1809 Jamison left for England, to attend as a witness the court-martial of Johnston for his part in the affair of Governor Bligh. He died there in 1811 (MacPherson, 1933).

Thomas Jamison's son, Sir John Jamison, born in 1776, was, like his father, trained as a surgeon and appointed to the Royal Navy. When serving with the Baltic Fleet, he was knighted by the King of Sweden for notable services performed during an epidemic of cholera in the Swedish Army, and was permitted by the British authorities to use the title. On his father's death in 1811 he inherited his considerable property, and he came to Sydney in 1814. Here he engaged in pastoral pursuits, and at his death in 1844 was one of the most distinguished citizens of the colony. Jamison Street, Sydney (the spelling of which was recently corrected), and the Jamieson Valley (still misspelled) were named after him.

Thomas Jamison's article was reproduced, with modifications, by Cumpston (1914). It is reprinted here, from *The Sydney Gazette*, by courtesy of the Mitchell Library, Sydney:

General Observations on the Small Pox.

By Thomas Jamison, Esq., Principal Surgeon.

An erroneous opinion, in relation to the Small Pox, being generally received, and as an inference deduced therefrom equally fallacious with the principle upon which it is founded, I conceive it a duty incumbent on me, as Principal Surgeon of this Colony, to remove prepossessions which, if adhered to, must be productive of the most calamitous consequences to the Rising Generation of these Colonies.

First, it is conceived by a number of parents and others, having the care of children, that they have had the small pox in a natural way; and secondly, that little danger is to be apprehended from its effects in this climate. In refutation of a conjecture fatal to be indulged, I must observe, the disease by some considered as the small pox is no other than an eruptive appearance on the skin, proceeding from climate and other constitutional causes: Others may be deceived by the chicken-pox—an error that may be readily imbibed by those who are not conversant in the natural small pox; for I most positively affirm, on my own personal knowledge for ten years past, that not a single instance of the latter disease has occurred in this country.

It was generally accreditted by the Medical Gentlemen of the Colony on its first establishment, that the small pox had been introduced among the Natives by the crews of the French ships then lying in Botany Bay; but since that period no vestige of that disease has ever appeared.

In contradiction to so ridiculous an idea that the natural small pox should not carry with it, and be productive of effects baneful and destructive in the extreme, I have here to observe, that at the Cape of Good Hope (the latitude being nearly the same with this place) the inhabitants dread the appearance of the small pox, as in other countries they do a plague, from the fatal malignity of its tendency and effects; and I have no doubt, that should the disease ever visit this colony in a natural state, and particularly in the summer season, it would carry off nine-tenths of those who might receive the infection.

From the foregoing facts and circumstances, I would earnestly recommend Parents to avail themselves of the blessing held out to them by the provident care of the Parent Country, by having their Children inoculated with the *Vaccine* or *Cow Pock*—an infallible Preventative of that loathsome, disgusting, and too often fatal disease, when taken in the natural way.

It is almost needless to remark further on the particular virtues and properties of a discovery, announced and recommended to public notice, for the general benefit, from such high and indisputable authority; I shall therefore only remark, that the preventative qualities of the Cow Pock are incontrovertibly established: no preparatory regimen or extraordinary care are requisite in its application or progress; it is attended by no sort of danger or external blemish; wherefore, should parents delay to embrace the salutary benefit now tendered gratuitously, and the Vaccine Infection be lost, the most distressing reprehensibility may accrue to them from their remissness in the preservation of their Offspring, whose destruction hereafter may be reasonably apprehended to ensue from the small pox, should it ever visit this Colony in a natural state.

Acknowledgements.

Grateful acknowledgements are made to the librarian and staff of the Mitchell Library, Sydney.

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FRIGIDITY AND DYSPAREUNIA.[1]

By R. S. Ellery,
Melbourne.

The subject we are discussing this evening is a psychosomatic problem of some importance, which may have ætiological roots which are predominantly physical or preeminently psychological. I shall confine my remarks to the latter, which experience has led me to believe are more frequent than the former, though not always the more important.

The magnitude of the problem is apparent when one realizes that at least half the married women in our midst suffer from some frustration in their sex lives. Their happiness is marred, their social lives are undermined and their health is frequently jeopardized not only by their failure to achieve a satisfying orgasm, but by the neurotic symptoms which this defect causes.

The influence of childhood conditioning underlies the majority of cases of frigidity. When a child is brought up to regard sex as something unclean, is threatened with punishment for exhibiting an innocent sexual curiosity, and develops a guilt complex over the possession of any sexual feelings or erotic desires, the seeds have been planted for the development of adult frigidity. Though these prohibitions and threats may be forgotten and these early fears may have faded from the memory, their unconscious impulse is still present; and the organ involved can be stubbornly obedient to the old prohibition despite the wishes and the reasoning of the adult. Marriage gives a legal—and, if you like, a religious—sanction; but it does not obliterate the earlier prohibitions.

[1] Read at a combined meeting of the Honorary Medical Staff of the Women's Hospital, Melbourne, and the Australasian Association of Psychiatrists, on June 9, 1953, at the Women's Hospital, Melbourne.

The sexual act is a complementary phenomenon. We should remember this when dealing with the problem of frigidity. The sexual organs of both sexes are complementary in an anatomical sense, and coitus represents a complementary expression in the psychological respect. The male role of aggression is complementary to the female role of reception. The failure of either party to display what is psychologically normal in this respect may therefore entail defeat, and the cause of female frigidity must be sought in the examination of both parties. A man may, for any one of a number of reasons, lack the necessary aggressive drive, or the woman may be without the necessary receptive impulse.

A man may be responsible for his wife's frigidity through one of the following causes: (i) amorous ineptitude; (ii) premature ejaculation; (iii) partial or complete impotence. Many husbands, though well-meaning, through ignorance and/or inexperience, are saddled with the burden of amorous ineptitude, and bring to the marriage bed a technique so faulty and inadequate that their more sensitive partners are hurt, appalled, disgusted and robbed of any pleasure in the act which might have led to an orgiastic climax. The oftener such a gauche approach is made, the more settled become the negative reactions of the wife until the idea of frigidity is established.

Precocious ejaculation is commonly the result of sexual inexperience and may prove a shattering ordeal to both parties; and if it continued it could easily become one of the factors in the development of female frigidity.

Male impotence is generally psychological. It is often the result of fear, shyness or a sense of guilt engendered by a subconscious feeling of wrong-doing. Wrongly interpreted by the woman as loss of affection in her husband, it may cause an estrangement or set up a suspicion of infidelity strong enough to disrupt the tenor of married life. Obviously it may become one of the causes of frigidity.

Frigidity is a relative term. Few married women, I think, are completely frigid. Most of them will admit to an occasional orgasm. Some say that they find a mild pleasure in intercourse, but that this seldom, if ever, leads to complete satisfaction; while some experienec no pleasure at all, but do not feel any special repugnance to the act and conceive it as part of their marital duty to satisfy their husband's importunate demands. Of the remainder, there are some who display an aversion to intercourse and a few who find it painful through the development of some degree of vaginismus. This, of course, is an unconscious defence mechanism when intercourse is attempted by a severely inhibited woman. A more common form of frigidity is that displayed by women who experience normal excitement at the masculine approach, but who fail to achieve any satisfactory orgasm as the result of coitus.

The majority of those who are apparently frigid but display no aversion to sexual intimacy are found capable of experiencing intense sexual pleasure, culminating in orgasm, as the result of clitoral stimulation. The belief most widely held about such cases is that in the normal uninhibited woman sexual intercourse causes a transference from clitoral to vaginal orgasm, and that in true frigidity, owing to a sexual neurosis bound up in an infantile fixation, this transference cannot take place. Such a woman, therefore, remains emotionally infantile, clitoral stimulation alone being able to arouse her sexual feeling to the point of orgasm. Clitoral stimulation—a widespread indulgence in married women for the purpose of obtaining relief from sexual tension—is therefore a form of autoeroticism, no matter how or by whom the clitoris is stimulated. Half a loaf is better than no bread. But when such women admit that in sexual intimacy they experience orgasm only when assisted by their husbands, one wonders whether they are really frigid or whether the assistance required is due to the husband's ejaculatory precipitance or to some more recondite failure in the male technique.

If we go further into the psychological aspects of this subject, there are three items which play a provocative role in frigidity: (i) fear, (ii) hostility, and (iii) conflicting love. Fear is a very strong and a very widespread emotion. Its effect can be utterly crippling to the mind. Psychological trauma may induce fear. Girls who have suffered aggressive sexual assaults may, if improperly handled by parents, grow up to find they have a deep-rooted distaste for the normal sexual encounter. In this category I would place girls who may have suffered from attempted rape, those who, sometimes returning from school, have been chased by men, or have been subjected to indecent exposure by men, or have been interfered with by amorous relatives.

Again, I believe that pre-marital intercourse, with its often intense fear of pregnancy, may, in certain instances and in certain individuals, become a psychic trauma which is able to induce frigidity. Fear of criticism and ridicule, fear of injury, fear of pain and fear of pregnancy can all play their part. The stringent sex taboos in childhood may easily lead to a psychological revulsion in the adult woman. Where normal sex curiosity in a little girl has been met with parental evasion, embarrassment, or threat, where sex has been dismissed as dirty, disgusting and sinful, the child is wrongly conditioned to a natural impulse, and frigidity may ensue. The guilt feeling which arises from parental threat may completely imprison the sexual feelings in the impregnable fortress of frigidity. Conscience, that often rigid repository of right and wrong, develops during childhood, and when a parent strongly disapproves of a childish action, though the incident may have long been forgotten, the disapproval often exists and remains impervious to argument and reason. So the bogies of sex in childhood cannot be reasoned away; and not only the bogies of childhood. The growing girl may listen to the recriminations of a frigid mother, soured in the arid encounters of her own sex life, and come to the marriage bed with a mind already poisoned against the delights of intimacy. How often in the consulting room have we heard the confession that "Mother never told us anything", so that the uninstructed bride recoils at the first jab of pain; or "Mother said that sex was something women had to put up with"? And so the young woman, afraid of intercourse, steels herself against the dreaded impact and feels the very discomfort that she anticipated.

Fear of pregnancy may be real or may be a conscious rationalization of an unconscious distaste. In either case it can become a severe inhibitor of sexual expression. Among the many old wives' tales which cling to the sex act is that if a woman remains free from sexual excitement during coitus she will not become pregnant. Any slight degree of frigidity, then, is likely to be deeply frozen by a disinclination to become pregnant.

Psychological analysis has demonstrated beyond the slightest doubt that unconscious hostility is one of the commonest causes of frigidity. In the emotional cross-currents of the parent-child relationship a girl's reaction to her father or her brothers may be so strongly antagonistic that, though this is completely hidden from consciousness, she cannot enter into any intimate relationship with a man. She cannot surrender her body to the symbol of her unconscious hatred. She cannot yield to him, though she believes she loves him, nor can she allow him to make her happy because he represents the object of her antagonism. Repressed hostility baulks her love. For love is like a ship at sea. Above the water-line the wind catches the sails and moves the ship; but below the water-level, unseen, the rudder and the current determine the course the ship takes. It is these unseen and unknown factors below the level of consciousness which condition our behaviour. And in the instance just quoted the current of hostility alters the course of conduct. The penis, as emblem of her hatred, is rejected. If the force of her rejection is strong, an attempt at coitus will cause vaginismus, wherein she literally and unconsciously shuts the door upon the intruder.

Some women grow up with what the psycho-analysts call a penis-envy complex, and in married life they resent this organ because they appear to have been robbed of it, and because it seems to give the man the power of dominance. Their frigidity lies in the hostility of this resentment.

This unconscious attitude is often seen in women who have compensated for this complex in becoming themselves dominant in character, as business executives, manageresses, officials, and in generally being prominent in affairs where men are accustomed to prevail. Theoretically, the suffragette has this hostility to male dominance, and frigidity is likely to be her sexual characteristic.

Under my third heading, conflicting love, I would place women with a marked father fixation, latent homosexuals and those of narcissistic type whose self-love is so overflowing that they cannot love anyone else, and in sexual relations would find themselves frigid.

The woman with a father fixation will marry someone who satisfies the father ideal, only to find that intercourse imposes the spectre of incest between her husband and her orgasm. I said "spectre" designedly, because the incest idea is seldom tangible. It lurks unseen and unsuspected, but is nevertheless an obstacle to satisfactory coitus.

Frankly perverted women seldom marry. Their interest in and attachment to members of their own sex render them immune to the blandishments of men. Those who are aggressively masculine in character are generally repellent to men, although a few, perhaps impelled by mistaken motives, may seek marriage with men of markedly feminine type, only to find that such a union is as hopeless sexually as it is impracticable. Lesbians of the passive type who display the normal female characteristics are much more likely to be led into matrimony. Some are bisexual and able to achieve sexual gratification with either sex; but the majority are deceptive and may not discover their latent lesbianism until after marriage. Brought up to believe that marriage is the destiny of the average woman, they allow themselves to be led to the altar and finally to the bedroom, which then becomes the slaughterhouse of love.

Sex is a stern taskmaster whose dictates may not be denied. What takes place at the inept amorous encounters which follow marriage, when elemental desires come crashing through the golden gossamer of romance, when "the imbecile earnestness of lust" disfigures the male countenance and tears of shame stain the cheeks of yesterday's bride, whose mind is ill-prepared to meet normal demands, is perhaps better left unspecified. Love makes a concord of the senses for the delight of the spirit; but for those who are unprepared or misinformed, who suffer from childhood complexes, and who cannot summon knowledge and understanding to their aid, the result is likely to be one of discord and disillusionment. When the wheel is broken at the cistern and love lies bleeding in defeat, the divorce court may offer the only way out for those who so blindly intruded. Otherwise there is the protracted martyrdom of living out a loveless union (and how often is this the case), growing old in servile make-believe, watching the coarse and ugly domestic pursuits become coarser and uglier, the squalid details of the bedroom routine become more squalid and the wearisome habits more wearisome, as that which began with myrrh and frankincense ends in a sagging paunch and curling-pins.

With this unattractive picture in mind, it may be thought that the prognosis in these cases is generally poor. Actually it is not good, but by no means hopeless. Though it should be assessed individually with each case, due regard being paid to the amount of psychological deviation present and to the intelligence and integrity of the patient, it may be said generally that subjects with latent homosexuality have not a good outlook; nor have those women who by compensation have developed a character dominance. A poor prognosis usually goes with those women who exhibit considerable emotional immaturity, who have never grown up, but have remained almost completely subjugated by their mothers. Apart from those already mentioned some success may be attained; but its measure depends upon the quality of the treatment.

This, in my opinion, should be psychological, and will require both time and patience. There is no short cut, no sovereign remedy. The surgery of the mind is more tentative than that of the body. It is both idle and dishonest to tell the patient that her sexual life will adjust itself after childbirth. You cannot cure frigidity by proposing pregnancy. It is likewise wrong to jump to the conclusion that frigidity is caused by fear of pregnancy and let the matter rest by suggesting some contraceptive device. It is still more dishonest to recommend some surgical procedure merely in the hope of doing good. I have had women come to me who have undergone uterine curettage for frigidity, and others who have had an allegedly cystic ovary removed for the same reason. Some women are given œstrogenic treatment, which may increase the libido, but which does not serve to remove the psychological obstacles to full sexual satisfaction.

Suggestion is a very powerful therapeutic weapon, especially in psychological illness, and apparently happy results have sometimes accrued from its use. The occasional success of some of the bogus surgical procedures is due entirely to the suggestive element. Suggestion may be reinforced by hypnotism and sometimes the results are dramatic; but usually they are only temporary, because the hypnotic suggestion, which is a forceful command diminishing in its intensity, does nothing to uncover psychological difficulties. Hypnotism when not used as a dictation but as a means of recalling forgotten incidents seems a much more valuable and scientific procedure.

To my mind, however, the most satisfactory and enduring form of treatment is by patient psychological investigation. In most cases this need not follow strictly Freudian lines, but should consist of persistent interrogation and explanation. This may sound easy, because talking is the prerogative of most of us. Even the patients are sometimes incredulous and, expecting some ex-cathedra magic, will exclaim: "Do I really get better just by talking?" But the psychiatric conversation goes far beyond a mere chat, extended though it may be to a smile and a friendly pat on the back. It has to be painstaking and persistent. Often the ground has to be gone over again and again. Explanations of complicated phenomena have to be made simple and yet convincing. The patient's personality has to be carefully adjudged. Quite often it is necessary to break down the natural barrier of reticence—to induce patients to say things that they have never admitted to another soul. Frequently it is necessary to mould one's words into a sympathetic and acceptable speech; for when the secret recesses of a patient's mind are ultimately open to one, a clumsy approach, a trip of the tongue, a fancied rebuke, a word of undue familiarity may upset the whole project and the curtain of confidence is rapidly closed—and may not be opened again. To prevent this happening it is wise to take caution for one's guide—to walk slowly rather than hasten with too much speed. But psychological investigation, apparently so simple, is in fact an art in which not all are successful, and in which experience is the better part of knowledge.

THE VALUE OF EXFOLIATIVE CYTOLOGICAL STUDIES IN THE DETECTION OF CANCER.

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Recently I was able to spend ten weeks in the United States of America, where opportunities were available for me to study cytological methods for the detection of cancer and to assess their value to the clinician. Every assistance was given to me by members of the staffs of the University of California Cancer Research Institute and the San Francisco Hospital Cytology Laboratory.

General Discussion.

The detection of cancer by cytological methods means the recognition of single cancer cells, or small groups of cells, in specially stained smears from body fluids, tubes, cavities or tissues. Tumours, like many other tissues, may

continually shed cells, and when these cells are seen to differ significantly from normal cells, or from atypical benign cells, then an assumption of malignant disease may be made. A positive cytological report demands confirmation by tissue biopsy whenever possible.

It is necessary to have well-preserved cells for examination, since cells which have degenerated, either at the source of origin or through aging after exfoliation, are not suitable. It is not claimed that a well-preserved malignant cell can always be recognized as such; but for practical purposes an accurate diagnosis can be made in a significantly high percentage of cases. It must be pointed out that a negative cytological report in no way rules out malignant disease. We are indebted to Papanicolaou and Traut for the pioneer work on this subject.

Cells which are shed from malignant tumours usually differ from benign cells in a variety of ways, and the following points are considered before an opinion is given.

Characteristics of an Aggregate or Clump of Cells which Suggest Malignant Disease.

Cellular variations within the same group, particularly variations in nuclear size, density and contour, are of diagnostic significance.

The crowding of nuclei within groups, which is chiefly due to scanty cytoplasm, is significant only for nuclei of over 10μ in diameter. Sheets of columnar or squamous epithelial cells may appear crowded, but their nuclei are smaller than 10μ. Crowding may be distinguished from simple superimposition of nuclei by careful inspection of nuclear edges.

Clumping is rarely diagnostic, but is sometimes helpful when associated with other criteria, and may be described as the presence of smooth nuclear outlines without indentations within an aggregate of cells. This suggests that the group was independent of its previous environment. Clumping may also be associated with crowding.

Cannibalism, or the phagocytosis of one epithelial cell by another, is common in cancer, but may also occur in benign inflammatory conditions; therefore its presence in smears is of value only if the nucleus of the phagocytosing cell shows the criteria of malignancy.

Criteria for Individual Cells.

Huge nuclear size in individual cells is significant. A nucleus which measures over 25μ in diameter is strongly suggestive of malignant disease. The most common source of difficulty in this respect is the single endocervical cell, or other cells which may show enlargement due to mechanical distortion, although the bland chromatin pattern distinguishes this as an artefact.

The nuclear-cytoplasmic ratio is the ratio between the diameter of the nucleus and the width of the cytoplasmic border. Generally, cells with nuclei larger than 10μ which have a nuclear-cytoplasmic ratio greater than 2:1 are suggestive of malignant disease. The nuclear-cytoplasmic ratio is not significant in small cells.

Irregular nuclear contour is especially significant if the irregularity is jagged and if the general nuclear shape is asymmetrical. Some normal cells, especially histiocytes, may show smooth irregularity.

A thickened nuclear membrane is significant.

The characteristics of hyperchromatism (also important) are as follows: (*a*) simple massive hyperchromatism, in which the entire nucleus is opaque; (*b*) massive chromatin blocks, especially if eccentrically placed, with irregular outlines, or with a "smudged" appearance; (*c*) abnormal nuclear clearing, associated with hyperchromatism; (*d*) uniform distribution of abnormally coarse, unequal and irregularly distributed chromatin granules. False hyperchromatism may be found due to over-staining, although this is recognized by using the staining reaction of the leucocytes as a guide.

Nucleoli are usually seen as acidophilic, spherical objects which have a very sharp outline. They are sometimes basophilic, and are distinguished from chromatin blocks by their smooth border. Although abnormally large, multiple, or fragmented nucleoli strongly suggest malignant disease, they are not diagnostic as a single criterion.

Comment.

It is essential to remember that all malignant cells do not show morphological abnormalities, and that many may show only a few of the criteria associated with malignancy. Undoubtedly, many malignant cells are seen which cannot be distinguished from normal cells. Since smears seldom show only well-defined malignant cells and typical normal cells, the presence of slightly suspicious cells supports the likelihood of malignant disease. The presence or absence of mitotic figures used to be regarded as of little significance; but some recent study suggests that abnormal mitotic figures may sometimes be recognized in malignant cases.

The accuracy of cytological studies is inversely proportional to the stage of the tumour growth, since an early superficial tumour will shed more abundant and better preserved cells than a tumour which has invaded extensively, and whose desquamating surface has become necrotic. This is supported by the work of Bronk and Appel (1949), in which these authors transplanted Browne-Pearce carcinoma of the testis into the bronchial tree of rabbits. Swabs were introduced into the trachea of these animals, and cytological studies were made of the bronchial secretions so obtained. Malignant cells were found in secretions from 58% of the rabbits on the sixth day, and 100% of the smears gave positive findings by the end of the third week. The animals were sacrificed as soon as a positive bronchial smear was obtained, and sections were made in order to correlate the appearance of the tumour cells which were seen in bronchial secretions with the grossly recognizable tumours in the bronchi. In none of the animals in the bronchial secretions of which malignant cells were found at six days was the tumour recognized by gross examination, although small nodules of tumour were seen on microscopic examination of sections. The earliest tumours were demonstrated by macroscopic examination at about fifteen days after transplantation.

It is fortunate that the cytological technique is more suitable for the detection of early tumours, because they are the ones most difficult to recognize by other methods. This problem is particularly pertinent to the early detection of carcinoma of the lung and cervix. Cytological studies have frequently led to the diagnosis of carcinoma *in situ* in the cervix (Scapier, Day and Durfee, 1952), as well as to an occasional report of carcinoma *in situ* in the lung (Umiker and Storey, 1952; Papanicolaou and Koprowska, 1951). In one case of the latter the lesion was too small to be seen macroscopically.

Lung Cancer.

Dr. Seymour M. Farber and his associates at the University of California Medical School, and numerous other workers (Farber *et alii*, 1948; Herbut and Clerf, 1946; Woolner and McDonald, 1947; Wandall, 1944) have made a great contribution to the detection of lung cancer by cytological methods. Farber, Benioff and Smith (1952) make the following statement:

> There are three techniques of primary significance to the diagnostic problems of cancer of the lung.
>
> Roentgenologic evidence is suggestive but not conclusive unless confirmed by other means. Because pulmonary cancer masquerades, morphologic proof is needed.
>
> In some cases bronchoscopy can provide proof, but its usefulness is limited to lesions in the major bronchi.
>
> For the third technique, cytologic study, to be effective, apparently it is necessary only that there be a free passageway between the trachea and the tumour body.
>
> Wider application of this simple and relatively inexpensive technique may greatly aid in the solution of diagnostic problems of pulmonary cancer.

Farber, McGrath, Benioff and Espen (1951) give the following summary of their work:

(i) Six thousand two hundred and eighty-one specimens of sputum or bronchial secretions from two thousand and sixty-six persons were studied by cytologic techniques. Two hundred and forty-one patients had bronchogenic cancer diagnosed by pathologic studies.

(ii) A positive cytologic diagnosis was made in 55% of these 241 patients. When five or more sputum specimens were examined, the accuracy rose to 90%.

(iii) The clinical applications of cytologic techniques are discussed:

(a) Cytology is of value to the thoracic surgeon in establishing a reliable pre-operative diagnosis of lung cancer.

(b) A positive cytologic diagnosis may be made in many cases where the lesions are located in the periphery of the lung or upper lobe bronchi where bronchoscopic examinations are of limited value.

(c) Difficult diagnostic problems may be solved when a definite morphologic diagnosis of cancer is made by positive cytologic studies.

(d) In patients with coexistent pulmonary tuberculosis and bronchogenic carcinoma, cytologic studies may clarify a confusing clinical picture.

(e) Cytologic studies of sputum may be utilized as routine screening procedures on patients with minimal or no pulmonary symptoms.

(iv) In our series of pathologically proved bronchogenic carcinomata, a positive cytologic diagnosis was made oftener and sooner than other morphologic diagnoses. In 47% of these cases, cytology was the first diagnostic procedure to establish a morphologic diagnosis.

(v) *Earlier diagnoses will be made* when cytologic techniques are applied immediately after cancer is suspected.

(vi) *Earlier diagnoses will be made* when this diagnostic method is utilized on patients with equivocal lung lesions detected by routine roentgen surveys.

(vii) *Earlier diagnoses will be made* when patients with cough and sputum—whether cancer is suspected or not—are routinely studied by cytologic techniques.

The incidence of lung cancer appears to be increasing annually by 5% to 10% over each previous year, and the mortality rate remains over 90%. Surgical removal of the tumour at an early stage is the only cure at present, and cytology appears to offer the best chance for its early detection.

Bronchiolar (alveolar cell) carcinoma, which is said to account for 5% of all lung cancer, also gives typical groups of cells in most instances (Storey *et alii*, 1953; Farber *et alii*, in the press).

Full details of the technique of preparing, staining, and evaluating the material from sputum can be found in the book by Farber, Rosenthal, Alston, Benioff and McGrath (1950).

Recent study suggests that the cellular contents of sputum may be concentrated by the use of mucolytic substances (Farber *et alii*, 1953).

Uterine Cancer.

A great deal has been reported on cytology in cervical and uterine malignant disease since the monograph by Papanicolaou and Traut appeared in 1943. A more recent publication by the staff of the Vincent Memorial Hospital in Boston (1950) gives complete details of cytological technique and interpretation, with special reference to the female genital tract. This book is well illustrated, has a comprehensive bibliography, and is highly recommended.

Cytological study of vaginal smears is most valuable under conditions in which biopsy is not clearly indicated—for example, in cancer detection clinics or in routine examination of women aged over forty years. The method is appealing because of its simplicity, since smears can be made by any practitioner in his own surgery, and with very little trouble to his patient or himself. The smears are fixed when wet, in equal parts of 95% ethyl alcohol and ether. After two hours in the fixative they may be removed and sent to the laboratory for staining and evaluation. Reports should be available within twenty-four hours. Extreme caution is necessary in interpreting smears made during pregnancy, or in the presence of trichomonad infection, and to a lesser extent after œstrogen therapy or irradiation of the pelvic organs.

Stomach Cancer.

Examination of stomach material has been less successful to date (Seybolt *et alii*, 1951; Traut *et alii*, 1952), partly owing to the gastric mucus interfering with the collection of cells. However, the use of an abrasive balloon (Panico *et alii*, 1950) and of "Papain" and allied mucolytic substances promises to eliminate this difficulty at least in part. Grimes, Traut, Wood and Farber (1954) conclude their paper as follows:

> A brief report of the contribution of papain lavage technique to the effectiveness of gastric cytology is presented, and four cases studied by this method are described. In three of these cases, cytologic study demonstrated the presence of cancer after other diagnostic methods had failed to yield conclusive evidence. Resection was possible in each instance, and the patients are apparently free of disease to date, from three years to forty-two months after operation. These cases emphasize the value of cytology in detecting malignant lesions of the stomach while they are still not only resectable but in a stage in which surgical treatment may effect long term cures, rather than merely palliative results. It is suggested that a wider use of cytology as a routine method of evaluation of gastric symptoms can make a substantial contribution to the control of malignant lesions. Its use is mandatory, we believe, in the diagnosis of any gastric complaint in patients over fifty years of age.

Kidney, Bladder and Prostatic Cancer.

Malignant cells are often found in the urine of patients with carcinoma of the bladder, kidney or prostate, although some difficulty is experienced in distinguishing between exfoliated malignant cells which may show few characteristics of malignancy, and the transitional epithelial cells which may demonstrate many features of malignant cells. Although the urinary tract is, perhaps, the weakest field of cytological application, some tumours, particularly frank adenocarcinomata, can be detected with accuracy. Papanicolaou (1947) has reported the details of neoplastic changes in cells of urinary sediment, and a case which he reported with Foot (1949) is a striking illustration of the value of this method. Tumour cells were found in the urine of a patient and were identified, by study of both right and left ureteral specimens, as coming from the right ureter. All other findings were negative, and a "normal" kidney was removed. On examination of sections, however, microscopic but indisputable evidence of carcinoma was found. (At a meeting of cytologists Dr. Papanicolaou admitted that he had spent some sleepless nights waiting for the sections to be cut.) Prostatic secretions, or a urine specimen after prostatic massage, can be examined cytologically with an expectation of accuracy comparable with urine studies. The reports of P. A. Herbut are recommended for details of the technique and findings (Herbut, 1949; Herbut and Lubin, 1947).

Colonic Cancer.

Some authors have reported good results in applying cytological techniques to the detection of cancer of the rectum and colon (Bader and Papanicolaou, 1952; Wisseman, Lemon and Lawrence, 1949). The bowel is first emptied by castor oil and enemata, and then washed out with saline for the collection of cells.

Tumour Cells in Fluids.

Exudates of neoplastic origin usually contain an abundance of well-preserved tumour cells (Saphir, 1949; Sattenspiel, 1949). Unless these cells are in clumps, they may be confused with the aberrant mesothelial and reticulo-endothelial cells which are normally present. It is wise to make sections of a "button" of the sediment by the usual paraffin method as an additional step in the study of these fluids. The finding of tumour cells in pleural or ascitic fluid is of little help to the patient, since it indicates

secondary malignant growth; but it may be useful in establishing the diagnosis in confusing cases.

Miscellaneous Sites.

Diagnoses of cancer of the biliary tract and of the pancreas have been made from the examination of duodenal aspirations (Lemon and Byrnes, 1949), and examination of breast secretions may also reveal tumour cells (Eisen and Taft, 1951). Other studies have been made on cerebro-spinal and synovial fluid, smears from larynx and naso-pharynx, and direct smears from skin lesions.

Comment.

The cytological detection of cancer has been developed by trial and error to a stage at which it has earned a definite place as a diagnostic tool. Although the method has been neglected to a large extent in Australia, it is thought that as the advantages of the technique come to be appreciated, it should and will be used widely in the future.

Summary.

1. The cytological identification of malignant cells is defined.

2. The application and expected accuracy of cytological studies of cells found in various body fluids are discussed.

3. An appeal is made for greater use of this technique in Australia.

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Reports of Cases.

A TRIPLE INGUINAL HERNIA.

By J. W. GRAHAM,

Sydney.

In most cases an inguinal hernia has a single sac, either direct or indirect in type. Multiple herniation, when it occurs, usually takes the form of a double hernia consisting of a direct and an indirect sac whose necks are separated by the inferior epigastric vessels. More rarely a double inguinal hernia consists of two direct protrusions into the canal, and cases of this type have been described by Corlette (1914) and by Goldowsky (1941). In the case to be described here three hernias had occurred into one inguinal canal. I can find no previous record of a triple inguinal hernia.

Clinical Record.

X., a male sedentary worker, aged sixty-six years, presented with the complaint of a lump in the right groin, which he said had been present for twelve months. *Examination of the patient revealed a reducible, oblique* scrotal inguinal hernia on the right side. Operation was carried out on February 8, 1954, by Dr. V. M. Coppleson. *After the inguinal canal had been opened and the spermatic* cord retracted, three separate hernias were seen to be present. One was contained in the spermatic cord, being of the oblique type with a sac about five inches in length. The other two hernias were of the direct type, having come *through separate defects in the conjoint tendon. These* defects were circular and lay side by side near the lower border of the tendon. The neck of each direct hernia was about half an inch in diameter and they measured one and a half inches and two and a half inches in length. The more lateral of the direct hernias was the larger and consisted of extraperitoneal fat, containing a peritoneal sac and part of the urinary bladder. The other direct *hernia consisted of extraperitoneal fat only. The peritoneal*

sacs were ligated and, together with the herniations of extraperitoneal fat, were excised. The defects in the conjoint tendon were closed and a Bassini type repair with "sliding" of the anterior rectus sheath was carried out. The patient's subsequent convalescence was uneventful.

Discussion.

The direct hernias in this case were of the less common, funicular type. This type of hernia occurs through a small defect in an otherwise normal conjoint tendon, whereas in the more common type of direct hernia there is a wide-necked bulge resulting from a diffuse yielding of an attenuated conjoint tendon. Because of the difference in the size of their necks, a funicular direct hernia is liable to become strangulated, whereas a diffuse one rarely does so. A funicular direct hernia probably commences as a protrusion of extraperitoneal fat through a vascular foramen. The medial hernia in this patient had not progressed beyond this stage. The association of two direct inguinal hernias with a third oblique hernia on the same side in this case was regarded as a rare coincidence and on that account is reported.

Acknowledgement.

I am indebted to Dr. V. M. Coppleson for permission to report the findings in this case.

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SPASMODIC OCCLUSION OF THE RADIAL ARTERY OF TWELVE HOURS' DURATION.

By A. W. Metcalf, M.B., B.S.,
Sydney.

Thrombosis and occlusion of the cerebral and coronary arteries frequently occur, and intermittent claudication is a well-recognized clinical condition, but spasmodic occlusion of the radial artery must be a rare observation.

Clinical Record.

The patient, a male, aged seventy years, had been under treatment for myocardial degeneration with evidence of congestive cardiac failure for at least one year. Treatment with a mercurial diuretic ("Thiomerin Sodium") and digitoxin (in the form of "Purodigin") had kept him reasonably compensated and partly ambulatory. He had been in the habit of observing his own pulse in the right wrist for irregularity and rate. On the morning of March 11, 1954, he was awakened with numbness in the right forearm and hand, and on feeling for the pulse found that it was absent. On his retiring it had been observed as usual. Some pallor of the hand was also noted.

When I arrived at 10.30 a.m. I also failed to feel the radial pulse, but observed the brachial artery pulsating forcibly. After a further half-hour the pulse suddenly became evident, with improvement in the colour of the hand and disappearance of the numbness. Further observation showed a variation in the blood pressure in the right and left arms, the figures being 176 and 162 millimetres of mercury, systolic, and 116 and 110 millimetres, diastolic, respectively. Two days later equal blood pressure recordings were found—164 millimetres of mercury, systolic, and 108 millimetres, diastolic.

Comment.

The causes of this phenomenon were thought at the time to be as follows: (i) endarteritis of the radial artery, which had occluded the vessel during the above-mentioned period of observation; (ii) thrombosis; (iii) spasmodic occlusion. In view of the spontaneous return of circulation it appeared that the last-mentioned condition had occurred.

Books Received.

[The mention of a book in this column does not imply that no review will appear in a subsequent issue.]

"Why We Became Doctors", edited by Noah D. Fabricant, M.D.; 1954. New York: Grune and Stratton. 8½" × 6", pp. 192. Price: $3.75.

In this book fifty well-known medical men and women give their reasons.

"The Doctor Writes: An Anthology of the Unusual in Current Medical Literature", edited by S. O. Waife, M.D., F.A.C.P.; 1954. New York: Grune and Stratton. 9" × 6", pp. 182, with eight illustrations. Price: $3.75.

Articles collected from various medical journals and reprinted in book form.

"Practice of Allergy", by Warren T. Vaughan, M.D., revised by J. Harvey Black, M.D.; Third Edition; 1954. St. Louis: The C. V. Mosby Company. Melbourne: W. Ramsay (Surgical), Limited. 10" × 7", pp. 1184, with 335 illustrations. Price: £11.

The second edition was published five and the first edition fifteen years ago.

"Directory of International Scientific Organizations: Unesco", Second Edition; 1953. Paris: United Nations Educational, Scientific and Cultural Organization. 9½" × 6½", pp. 316. Price: 17s.

Gives information on international organizations whose activities deal with the various branches of science.

"Diencephalon: Autonomic and Extrapyramidal Functions", by Walter Rudolf Hess, M.D.; 1954. New York: Grune and Stratton. 9" × 5½", pp. 92, with 33 illustrations. Price: $4.00.

This is Volume III of "Monographs in Biology and Medicine" issued by the publishers.

"Practical Fluid Therapy in Pediatrics", by Fontaine S. Hill, M.D.; 1954. Philadelphia and London: W. B. Saunders Company. Melbourne: W. Ramsay (Surgical), Limited. 9½" × 6½", pp. 296, with 20 illustrations. Price: 57s.

The purpose of the book is to present basic principles of fluid and electrolyte therapy in such a way that they may be applied at the bedside.

"The Care of the Aged (Geriatrics)", by Malford W. Thewlis, M.D.; Sixth Edition; 1954. St. Louis: The C. V. Mosby Company. Melbourne: W. Ramsay (Surgical), Limited. 9½" × 7", pp. 832, with 155 illustrations. Price: £7 17s. 6d.

The first edition appeared nearly thirty-five years ago.

"The Medical Clinics of North America"; 1954. Philadelphia and London: W. B. Saunders Company. Melbourne: W. Ramsay (Surgical), Limited. Mayo Clinic Number. 9" × 6", pp. 310, with 73 illustrations. Price: £7 5s. *per annum* in cloth binding and £6 *per annum* in paper binding.

This Mayo Clinic number is a symposium of thirty-three articles (with a foreword) on bronchial and pulmonary disease.

"The Surgical Clinics of North America"; 1954. Philadelphia and London: W. B. Saunders Company. Melbourne: W. Ramsay (Surgical), Limited. Lahey Clinic Number. 9" × 6", pp. 284, with 59 illustrations. Price: £7 5s. *per annum* in cloth binding and £6 *per annum* in paper binding.

This number contains a symposium of thirty articles on surgical procedures on aged and poor risk patients. There are three extra articles. It is a Lahey Clinic number.

"Laboratory Techniques in Rabies"; contributors: D. d'Antona, P. Atanasiu, R. Béquignon, E. Falchetti, Karl Habel, George A. Hottle, Harald N. Johnson, Martin M. Kaplan, A. Komarov, Hilary Koprowski, Pierre Lépine, Thomas F. Sellers, Ernest S. Tierkel and C. Vialat; World Health Organization Monograph Series, Number 23; 1954. Geneva: World Health Organization. 9¾" × 6¾", pp. 156, with 51 illustrations. Price: £1 (paper bound) or £1 5s. (cloth bound).

A manual for laboratory workers written by fourteen rabies specialists in different parts of the world and covering laboratory diagnosis, methods of vaccine production, vaccine potency tests, the production of hyperimmune serum and the care and breeding of experimental animals.

The Medical Journal of Australia

SATURDAY, OCTOBER 16, 1954.

All articles submitted for publication in this journal should be typed with double or treble spacing. Carbon copies should not be sent. Authors are requested to avoid the use of abbreviations and not to underline either words or phrases.

References to articles and books should be carefully checked. In a reference the following information should be given: surname of author, initials of author, year, full title of article, name of journal, volume, number of first page of the article. The abbreviations used for the titles of journals are those adopted by the Quarterly Cumulative Index Medicus. If a reference is made to an abstract of a paper, the name of the original journal, together with that of the journal in which the abstract has appeared, should be given with full date in each instance.

Authors who are not accustomed to preparing drawings or photographic prints for reproduction are invited to seek the advice of the Editor.

WOMEN WORKERS AND FAMILY RESPONSIBILITIES.

FROM time to time attention has been drawn in this journal in various ways to the changing sphere of activities of women, and to some of the effects that this alteration has had on the social and economic balance within the community. In a leading article entitled "Women in Industry", published in 1944, the importance in this respect of the two World Wars was mentioned, and stress was laid on the need for safeguarding the health of women workers in industry.[1] It was pointed out on that occasion that women employed in industry were severely handicapped, especially the married woman with a family, who was doing two jobs. Apart from the physical strain to which she was subjected, she would scarcely ever be free of mental strain and anxiety. It was stated that the situation (at that time one of war-time emergency) presented an enormous question of future peace-time development, and reference was made to the strength of the maternal instinct, and to the need to do everything possible to preserve the health of the woman worker so that she might be able to fulfil her destiny. The problems involved have for some time been under consideration by the International Labour Organization, and an interesting report[2] on the present situation has been drawn up by Maria Baers, Member and Secretary of the Belgian Senate, and Secretary-General of the *Action sociale féminine chrétienne* in Belgium. Baers points out that for the first time in the history of mankind world-wide plans are on foot in many fields—economic and social life, food and agriculture, science and education, physical and mental health, the protection of mothers and children *et cetera*. Technical assistance is intensifying the pace of development among the nations; but there is a danger that this very development may become the source of fresh suffering and disorder, and even of far-reaching social disturbances that may take years to put right. In the planning of economic growth, the inevitable accompanying process of social change must be continually borne in mind. The problem, as Baers sees it, is "whether economic expansion, particularly in under-developed countries, is to take place in such a way as to demand the direct assistance of women, including mothers of families, or whether every effort should be made to secure for families the income needed for normal development without financial and economic contributions from mothers earned by paid work outside the home". Baers is concerned in this study particularly with the employment away from the home of mothers with young families; she does not attempt to deal with the problem of the employment of women in general in trades and professions. She believes that the varied reasons why mothers take work outside the home can be reduced to the following four basic factors: (i) permanent inadequacy of family incomes from fathers' work, resulting from the system on which the economy is based; (ii) temporary inadequacy of family incomes due to exceptional or accidental circumstances such as sickness, premature incapacity for work, temporary absence or death of the father, desertion, or occupational, moral or psychological shortcomings of the father; (iii) the mother's desire to contribute to family welfare by providing extra income from paid work; (iv) the influence of public opinion or the married woman's individual desire for economic independence. In her opinion the first of these is by far the most important, and she is certain that it is so in under-developed countries in which rapid economic growth is taking place. There poverty is very great and family allowances are non-existent, and it is accepted that the only solution is outside work by the mother. Baers believes that this state of affairs will continue until the principle is accepted, and acted on, that the father's work should be sufficient for normal family needs, no matter how many children there are. Such an adjustment will make necessary the granting of substantial family allowances in addition to actual earnings; if there is only one breadwinner in the household, this allowance may need to be supplemented by a special wife's or mother's allowance, or by a differential family allowance depending on whether or not the mother remains at home or goes out to work. Baers strongly holds the opinion that the mother's place is in the home if there are very young children or if there are many children in the family. She points out that it is questionable whether such a financial burden imposed on the community should constitute a final obstacle to such a necessary reform. There are also cultural, moral and psychological effects of mothers' work outside the home, and the difficulties that arise cannot be satisfactorily solved by the provision of day nurseries, crèches and similar institutions. Investigations carried out under the

[1] M. J. AUSTRALIA, June 17, 1944.
[2] *Internat. Lab. Rev.*, April, 1954.

egis of the World Health Organization have shown that with few exceptions the child is best cared for in his own home, even if the conditions appear to be entirely unsatisfactory. Moreover, the provision of institutions for the care of young children in order that their mothers may go out to work is wasteful and uneconomic. Turning to the second of the four reasons why mothers take up work outside the home, the need to make good a reduction of family income due to temporary or accidental causes, Baers comments that organized social security is needed to cover such events as the father's sickness, incapacity for work or unemployment. Family allowances, "single wage" allowances, mothers' household allowances and orphans' allowances are important. On the subject of mothers taking up employment because they wish to add to the income of the household, Baers states that the question must be decided by themselves and their husbands in the light of how family happiness may best be served. She believes that many working women could probably avoid the need to go out to work if they were better trained in the running of a household, and that therefore the problem is largely the educational one of training girls, and particularly young mothers, in home economics and family duties. She also points out that the extra income earned is considerably reduced by additional expenditure arising from the need to pay for care of the children, the increased cost of meals, the fact that clothes are less well looked after *et cetera*. The last of the four basic reasons why women take up work outside the home has three different components—public opinion, the attitude of employers and the attitude of the woman herself. In the working woman's social environment the attitude is current that women who do not combine work outside the home with their family duties may be regarded as lazy. Some employers fail to understand the burden that paid employment outside the home is to mothers of families; Baers points out that the lives of such women are little short of economic slavery, and their hours away from home tend to be filled with worry and anxiety. The attitude of the woman herself is often influenced by a certain type of feminist propaganda, "which insists on women's rights to a life of their own without having regard to the responsibilities undertaken in setting up a home and stresses women's right to work while forgetting their children's rights to a mother's care and affection". In 1945 we published a leading article entitled "Woman and the Population Problem",[1] in which an account was given of two "annexures" to a report of the National Health and Medical Research Council, the work of Dame Enid Lyons and Lady Phyllis Cilento respectively. Their opinions are apposite:

> . . . the mother no longer occupies the place of great honour that has always been assigned to her in the Christian civilization, in which she has been the theme of its greatest literature and its noblest art. A feminine type distinguished by a sophisticated youthfulness has supplanted her.

In the leading article referred to, the statement was made that there were some exceptionally gifted women who could have a career and bring up a family of children creditably; but generally it was a whole-time job. "The essential point is that woman's life should be planned within the ambit of her chosen or allotted sphere in such a way that it shall be full and many sided, balanced and honourable".

[1] M. J. Australia, May 19, 1945.

Having stated the problem, Baers discusses remedies. She remarks first of all that the necessary action is suggested in the account given of the difficulties themselves; and she believes that early action is imperative. Public opinion must be made aware of the magnitude of the problem. The long work of education and practical action is primarily the responsibility of workers', women's and family organizations. The interest of scientific circles must be aroused, to gain the support of economists, sociologists and doctors. While the need for ever-increasing production used to be stressed, now many economists are turning to the importance of properly directed household consumption, with a view to savings, particularly among wage-earners. Most important of all, the attention of employers' organizations and governments must be drawn to the problem. Baers believes that unless something is done very soon, millions of mothers in countries where technical assistance programmes are in operation will be in paid employment; no one can calculate how long it would take to undo the harm that would result. An attack must be made on the pressures driving mothers to enter paid employment. Legal measures are not likely to be of much use. Part-time work, if properly organized, may eliminate some of the deplorable results of the present full-time system. Another suggestion is that women aged over forty years may reenter employment. (This proposal would probably draw caustic comment from the unknown cynic who remarked in 1620 that "a woman is an angel at ten, a saint at fifteen, a devil at forty, and a witch at fourscore".) Baers believes that any programme for freeing the mothers of young children from the moral pressure resulting from the anti-feminine and anti-family bias of modern economic organization would have to include the following five main points: (i) family allowances; (ii) special allowances for mothers of young children who do not go out to work; (iii) part-time work; (iv) reemployment opportunities for women over forty years of age; (v) social security adjustments to meet such new arrangements for women's work. Baers has some important things to say also on questions of principle. She points out that for man and for woman, to live as a human being is to live in conformity with the laws of Nature. As man and woman are complementary beings, human progress can be achieved only through their complementary labours; but their cooperation is not restricted to the family—it can and must operate in all aspects of social life. Therefore she urges that all the necessary facilities for intellectual, vocational and moral training should be made available for women, "that the professions should be thrown open to them and that they be offered every opportunity for full participation in social life in all its various economic, intellectual, artistic, moral, political, national and international aspects". However, it is women's duty to choose the activities in which as women they can be of the highest service to society. The normal growth of the population is dependent on that of the family; it requires the full physical, intellectual, psychological and moral cooperation of the mother. As George Amiel put it in his *Journal*: "Woman is the salvation or destruction of the family. She carries its destinies in the folds of her mantle." Baers takes the view that the words "motherhood" and "the family" have a wide connotation; she believes that women will be most likely to play a useful

and successful part in activities that offer scope for the aptitudes inherent in the function of motherhood for which they are destined.

At the beginning of her report Baers stresses the fact that serious study of the subject is hampered by the dearth of scientific research material such as statistics, surveys *et cetera*. The importance of such material is apparently not appreciated by most of the bodies which might be expected to provide it. It is clear that Baers has gone to a great deal of trouble to correlate the information which she was able to obtain, and it is also clear that she is deeply concerned about the importance of the problem. No doubt arguments could be advanced in opposition to some of her statements; but it is unnecessary in this place to enter into such a discussion. In any case, most medical practitioners in this country will have come in contact with children who have presented physical or psychological problems, the cause of which may reasonably be considered to be deprivation of the mother's care during the early formative years, because the mother had found it necessary to take outside employment. Baers's report at least provides food for thought.

Current Comment.

THE CIRCULATION IN RELATION TO COLD ACCLIMATIZATION.

It is well known that the effects of acute cold exposure are peripheral vasoconstriction, diuresis and hæmoconcentration. Two questions arise in connexion with long-term exposure to cold or acclimatization to cold. First, is the vascular response to acute cold exposure different in the acclimatized person? Second, does the acclimatized person, as compared with the unacclimatized person, show changes in peripheral circulation when both are at a reasonably comfortable ambient temperature? These points are raised by G. Malcolm Brown *et alii*[1] in introducing a study that they have carried out of peripheral blood flow and of skin, subcutaneous, muscle and rectal temperatures in acclimatized and non-acclimatized subjects, both during acute cold exposure and at a comfortable ambient temperature. The cold acclimatized subjects for the experiments were chosen from Eskimos in the Canadian eastern Arctic, who still live the traditional native life and gain their livelihood by hunting, fishing and trapping, and are thus frequently exposed to cold. The non-acclimatized subjects were a control group of 85 healthy, male medical students. It was found, under experimental conditions, that amongst the Eskimos the forearm skin temperature and the forearm and hand blood flow were greater at rest in a room at 20° C. than they were in the control group of medical students. During immersion of the hand and forearm in water baths at temperatures of 5° to 45° C., the Eskimos always maintained higher blood flows in the hand and forearm than did the control group. With the colder baths, the forearm muscle temperature of the Eskimos fell more than it did in the controls, but this is believed to be due to greater blood flow through the exposed hand and the resulting increased cooling of deep tissues by the venous return. Brown and his colleagues state that the evidence is that the contribution made to the total thermal requirements of the body by the cooling of deep tissues was small. Exposure of the hand and forearm to cold caused a greater rise of blood pressure in the Eskimos than in the white men. There was also a difference in the pain perceived by the two groups. The Eskimos reported less severe pain and pain for a shorter period than did the controls. Brown *et alii* state that the experiments on peripheral blood flow suggested an increased heat production in the Eskimos, and an average elevation of basal metabolic rate of approximately 30% was found. There was also a rise of both plasma volume and total red cell volume. From a review of their own data and from data provided in other reports, Brown *et alii* conclude that there is support for the view that increased thyroid activity is a feature of the response to long-term exposure to cold and that the increased thyroid activity determines the pattern of the vascular adjustments which are made. They do not consider that an increase in the secretion of the thyroid hormone is necessarily the sole agent responsible, but it appears to be important.

[1] *Circulation*, June, 1954.

MYXOMATOSIS AGAIN.

On several previous occasions we have drawn attention in these pages to the use of myxomatosis in the control of rabbits. Further information is now to hand, in the form of a statement prepared by Mr. F. N. Ratcliffe, Officer-in-Charge of the Commonwealth Scientific and Industrial Research Organization's Wildlife Survey Section. Mr. Ratcliffe has found it necessary to set out the present position in some detail, because of a recent widely publicized statement to the effect that the rabbit problem could now be regarded as permanently solved by myxomatosis, and that the time had come to divert to other things the labour and materials employed on rabbit control. It is clear from what Mr. Ratcliffe writes that nothing could be further from the truth, and that three epidemiological factors, the probable effects of which had previously been foreshadowed, have now begun to limit the value of myxomatosis in the eradication of rabbits. These factors are the development of a resistant rabbit population, inadequacy of insect vectors, and a decrease in virulence of the virus.

It is now obvious that biological control cannot supersede the ordinary methods of eliminating rabbits. The official policy is to encourage the intensification of control by standard methods, to consolidate the gains obtained by myxomatosis by "mopping up" surviving rabbit infestations. Mr. Ratcliffe points out that this policy was decided on after careful consideration of all the facts and probabilities, and that it has been endorsed by the virologists and geneticists who have attended the myxomatosis conferences. He himself has done all in his power to advocate it, because he is convinced that its rejection would be a national calamity. In the optimistic statement previously mentioned, deductions were drawn from observations made in Brazil, the original home of myxomatosis and a country where the rabbit is not a pest; but the Brazilian "rabbit" is a different species from the European rabbit and is immune to the lethal effects of the myxomatosis virus. Also the assumption that the wild rabbit population in Australia will never acquire some degree of natural, heritable resistance to the virus is unfortunately mistaken. The reverse is almost certainly true. The only thing in doubt appears to be the number of years that will elapse before this resistance develops to such a level that the efficiency of myxomatosis as an agent of rabbit control will be significantly affected. The question of the rabbit's progressive adjustment to the virus has now become important. Recently, the Commonwealth Scientific and Industrial Research Organization's Animal Genetics Section has shown that the rabbit possesses heritable factors affecting its susceptibility to myxomatosis, from which selection can "work". At the myxomatosis conference held in Melbourne on July 28, 1954, to which we have previously referred,[1] Dr. J. M. Rendel stated that the development in the wild rabbit population of some degree of intrinsic resistance to myxomatosis was inevitable. The process of building up this resistance through selection, though slow at first, would be likely to become faster, and it would be enhanced by the prevalence of attenuated strains of the virus which permitted an increased percentage of rabbits to recover

[1] M. J. Australia, August 14, 1954.

from the infection. On that occasion Dr. Rendel could make no definite predictions, but he showed clearly that he was talking of changes to be expected in the near and not in the distant future. He now considers that a significant degree of resistance is likely to have become apparent within ten years in areas where annual outbreaks of myxomatosis have occurred.

The next factor to be considered is inadequacy of insect vectors, and this has already become operative. Although in each year there have been outbreaks of disease which could not be tied up with obvious insect activity, in south-eastern Australia the main effects of myxomatosis correspond closely in time and place with the seasonal activity and local abundance of certain species of mosquitoes. The vector situation determines the percentage of the local rabbit population that acquires the infection, and therefore it determines the maximum possible mortality. In certain areas in Australia, there are sufficient quantities of the right mosquitoes to produce something like 100% infection of the rabbit inhabitants; but these areas amount to only a small fraction of all the rabbit-infested country. Outside these areas there is a range of conditions, varying from country in which satisfactory "kills" may occur in most years, to areas where they can be expected only in an exceptional season, perhaps once in a decade or more. Concluding his statement on the insect vector position, Mr. Ratcliffe points out that there are many more details involved. It has to be realized that regional "kills" of 50% to 60%, even if they are associated with local pockets of higher mortality, are of purely temporary value and can be made good in a single breeding season.

Turning to the third factor, a decrease in the virulence of the virus, Mr. Ratcliffe points out that this will have an effect similar to that of increased resistance in the rabbit: it will reduce the maximum possible "kill" that myxomatosis can effect in the local rabbit population. He refers to Professor Frank Fenner's investigations at the Australian National University, which have shown that strains of the virus with a reduced virulence have appeared as a result of spontaneous variation, and that these strains are now widespread and appear to be becoming generally dominant. Two important problems arise in relation to this matter of decreasing virus virulence: (i) What does it mean in practice? (ii) Will it continue beyond the present stage, and, if so, how far? The attenuated strains that are now so prevalent will kill about 90% of infected animals, as compared with 99% killed by the original standard strain of the virus. The 10% of rabbits which recover are not susceptible to more virulent strains. There is a great difference between the effects of a fully virulent disease spreading through a completely susceptible population, as in the early outbreaks, and those of a resurgence of the disease due to an attenuated strain in an area where a proportion of the rabbits will be "recovered-immunes". When the presence of these immune rabbits, and the fact that a 100% infection of susceptible rabbits is exceptional, are taken into consideration, it is estimated that no more than an 80% "kill" among the local rabbit population is likely to be obtained. There is an interval of almost twelve months between epidemics, and in that time the survivors can stage a considerable recovery if conditions are reasonably favourable for breeding. Taking all the circumstances into account, Mr. Ratcliffe believes that if the virulence of the dominant strains of the virus slipped back to such an extent that the mortality rate was no more than 80%, the value of myxomatosis as an agent in the control of rabbits would be virtually lost. Professor Fenner's previously expressed tentative opinion that the virulence of the virus might be expected to become stabilized in the field at the 90% mortality rate level has since had to be modified. The only definite statement that can be made is that, although it is possible that the virulence of the dominant field strains may become stabilized at this level, it is by no means probable, and it is necessary to be prepared for the emergence and spread of less virulent strains.

Little can be done to modify the factors restricting the control value of myxomatosis. The number of mosquitoes depends upon the climate and the "luck of the seasons". The danger of increasing resistance in the rabbit population can be overcome only by destruction of the survivors from outbreaks of myxomatosis by standard methods. Professor Fenner, with the cooperation of the Commonwealth Scientific and Industrial Research Organization, is trying to establish in the field what it is hoped may prove to be a stable virulent strain of the myxoma virus. However, no claim for great or lasting success from these experiments can be made. Since the virus has shown a strong tendency to vary in virulence, and since as a general rule attenuated strains can be expected to spread at the expense of the more virulent strains, the danger that myxomatosis will provide progressively less assistance in the fight against the rabbit is very great. Mr. Ratcliffe states that he and his colleagues, and more recently Professor Fenner, have seen for themselves the degree of survival and recovery in population of rabbits in an area where the activity of myxomatosis was particularly intense (there was virtually a 100% local infection rate during three successive annual outbreaks). Certainly the rabbit population has been greatly reduced; but much infestation still persists. The present position seems to be that myxomatosis is following the pattern predicted for it. It is in the process of being so modified by the three epidemiological factors specified that it will soon cease to be of outstanding value in the extermination of rabbits. Therefore it behoves all conscientious landholders to make the utmost use of the advantages that the epizootic has gained for them, and to attack the surviving rabbits with every one of the standard means at their disposal.

WORK ADJUSTMENT AFTER PRE-FRONTAL LOBOTOMY.

An important aspect of the assessment of the results of pre-frontal lobotomy is the determination of work adjustment. This, if it is to have any practical significance, requires a lengthy period of observation. Pre-frontal lobotomy has been carried out at the Boston Psychopathic Hospital since October, 1943, so that it is now possible to examine its effects over a period of up to ten years. This has been done in relation to work adjustment by M. Greenblatt, M. Wingate and H. C. Solomon[1] in a follow-up study over a period of five to ten years of 86 patients who had undergone bilateral pre-frontal lobotomy for chronic mental disease. The patients had all been operated on according to Poppen's technique between October, 1943, and April, 1946. All had been chronically ill psychotic patients whose progress without operation was considered hopeless. The particular object of the study was to determine not only how much improvement followed lobotomy in relation to work capacity, but also whether the improvement was sustained over the years and especially how the post-operative level compared with the pre-operative level of work capacity both before illness and during illness. The findings indicate a great improvement of work adjustment after operation (Greenblatt, Wingate and Solomon describe the improvement as "vast"). However, the post-operative level was considerably below the best work period, namely, before the illness had begun. The work adjustment of patients who were in the community at the end of the follow-up period of five to ten years was considerably higher than that of the hospitalized patients, and nearly up to the level present before illness. However, hospitalized patients made significant gains in work adjustment compared to that before operation. The post-operative adjustment of housewives was very satisfactory considering their uniformly poor work adjustment during illness (all had been efficient housewives before illness). Comparison of the improved figures in a follow-up study of one to four years with those in the present five-year to ten-year survey reveals, in general, maintenance of improvement over the years; for hospitalized patients there is a strong suggestion that the work adjustment was better in the later than in

[1] *New England J. Med.*, May 20, 1954.

the earlier follow-up study. The results are considered by Greenblatt, Wingate and Solomon to be encouraging as an indication for further use of the lobotomy operation. The patients operated on were those whose work potential had been crippled by the illness. The operation succeeded in releasing, to a greater or lesser degree, the work potential of a substantial number of these patients, both in the hospital and in the community.

PORTENTOUS SHADOWS.

> You have shown me a strange image, and they are strange prisoners.
>
> Like ourselves, I replied; and they see only their own shadows, and the shadows of one another . . .
>
> PLATO.

THE true basis of science is observation of fact, yet perhaps half of all science is no more than inference. The inference may be, nevertheless, strikingly apt. The fact that nobody has seen an atom detracts no wit from the reality of atomic power, nor does our ignorance of the shape of electrons preclude their use for many practical purposes.

So far as the proper practice of medicine is based upon observation so far is it subject to the same limitations. But there is a further difficulty. The patient prizes the envelope which so snugly enwraps him and resents an intrusion purely for the sake of laying a part bare to direct observation. Diagnosticians, in consequence, have been at some pains to devise procedures which will provide reasonably reliable information while yet preserving the integrity of the investing cuticle. The various optical devices for exploring bodily cavities come to mind at once, but they do provide direct observation. The histologist who lives in an "Alice Through the Looking Glass" world of reversed pictures is getting closer to unreality, but his material is in his hand. Radiology is concerned with no more than shadows, though usually they are shadows of real things. But when the radiologist is driven to infer the existence of something from the effect it has upon something else, then he is in the same case as the physicist who infers the presence of one atomic particle from its effect upon another. And both are like the inhabitants of Plato's imaginary cave, where men judged of themselves purely by inference from the movements of their shadows.

In no field of diagnosis is the necessity for negative inference more apparent than in the skull. Here even the toughest "exploratory laparotomist" hesitates, while the patient—with less fortitude than his neolothic predecessor—does not lightly lend his head to the confirmation of a guess. Occasionally, of course, a calcified tumour or an expanded *sella turcica* provides the clue, but only too often some indirect method of making the lesion disclose itself is required.

One such method has been the injection of air—either around the brain (encephalography) or into the ventricles (ventriculography). An adroit manipulator can sometimes make the one injection serve both purposes. At all events, these procedures, comprehended under the title of "pneumography", continue to serve the invaluable purpose of revealing in a negative fashion the distortions imposed by intracranial lesions of either excess or defect within a rigid, closed brainbox. In 1927 the enterprising Moniz developed a more direct method of attack by injecting radioopaque material into the cerebral circulation—usually via the carotid route. Fairly intensive development of this work—particularly the introduction of percutaneous injection by Engeset and substitution of the diodone type medium for the potentially more dangerous thorotrast—have demonstrated that this procedure is a highly valuable complement to pneumography. Not only can intracranial distortions be outlined—aneurysms may be revealed, or the vascular pattern through the lesion may be conclusive for angioma, meningioma or glioma. This is mainly on the arterial side; but Moniz had already shown that successive photographs at appropriate intervals will show up the capillaries and the veins. By taking rapid serial radiograms Curtis and others have followed the passage of the contrast medium through the whole cerebral vascular tree and have determined the optimum times for making exposures. More recently Krayenbühl and Richter have demonstrated the value of good angiograms of the deep cerebral veins in the diagnosis and localization of deep-seated tumours.

This last is the subject of a recent monograph by Curt Johanson,[1] working in the laboratory of Lindgren—himself a well known exponent in this field. More than a third of Johanson's paper is taken up with anatomical considerations—first by direct dissection, then by radiographic investigation on cadavers and finally by confirmation on 179 "normal" living patients. Of this section one may fairly say that, while the check angiograms are good, the photographs of the dissections are not specially informative; moreover, the repetitious treatment makes one feel that the author has made a few veins go a very long way. A question that inevitably arises is: how were the 179 "normal" patients persuaded to undergo this rather heroic procedure? The anatomical section is then treated very thoroughly, but the account discloses nothing new; indeed, it reveals a decided gap, since the author is evidently unaware of the work by Kolisko, Abbie and others on the part taken by the anterior choroidal artery in the supply to the basal nuclei.

The clinical part of Johanson's paper is based upon eight patients with craniostenosis, 10 with hydrocephalus and 103 with a supratentorial expanding process. A diodone type medium was used, six millilitres being injected into the carotid artery percutaneously. Two exposures were made in the antero-posterior plane and three in the lateral—the last coinciding with the late venous phase which shows the central veins. A series of measurements from fixed points was devised to permit assessment of the amount of displacement of the deep veins. This section of the monograph contains a good selection of representative angiograms and explanatory figures. Apart from a few emendations in detail the paper as a whole does not contain anything very new. But it does confirm the value of this procedure and, being well illustrated and in English (the translation by Erica Odelberg is excellent), and providing a good bibliography, it will probably attract the favourable attention of a wide audience.

CHEMICAL CHANGES IN PASTEURIZED MILK.

IT has been known for some considerable time that heating milk alters the reaction, producing a shift to the acid side; this result is directly opposite to what one would expect to follow expulsion of dissolved carbon dioxide. Various suggested explanations have been put forward to account for this phenomenon, such as production of lactic acid from casein or from lactose arising from the boiling temperature. A very simple experiment reported by Socrates A. Kaloyereas[2] has disproved these assumptions. When milk is heated to 62° C. and kept for thirty minutes at this temperature (pasteurized, in fact) the same change occurs, whilst continued application of heat makes no alteration in the reaction. It is now shown that there is an increase of monocalcium phosphate and a corresponding decrease of dicalcium phosphate, carbon dioxide being used up in the formation of calcium carbonate. Titration curves of the rennet serum from raw and pasteurized milk show two characteristic differences at the points ending the titration of monocalcium phosphate and dicalcium phosphate. This simple titration procedure can be used to differentiate raw milk from pasteurized. Possibly other biological fluids display the same phenomenon.

[1] *Acta radiol.*, Supplement 107, 1954.

[2] *Science*, July 16, 1954.

Abstracts from Medical Literature.

SURGERY.

Treatment of Patellar Fractures.

Rudolph S. Reich and Norman J. Rosenberg (*Surg., Gynec. & Obst.*, May, 1954) have reviewed 68 consecutive cases of patellar fracture. Twenty-three patients had been treated by open reduction and suture, and of these 19 were available for study. Twenty-seven patients had been treated by a method of excision of all but the largest fragment of the patella, and 21 of these were available for study. In 18 cases, patellectomy was the procedure of choice, and in 16 of these the patients were followed up sufficiently for study. The authors state the following five conclusions: (i) Good results may be anticipated after open reduction and suture if there are only two fragments and the fracture is transversely situated near the waist; open reduction and suture are contraindicated in other cases. (ii) Good results may be anticipated after excision of all but the largest fragment if that fragment is the upper two-thirds of the patella and if the technique of suture is such that it will allow the patella to remain in normal relation to the line of the quadriceps pull and the femoral condyles; otherwise it is contraindicated. (iii) Excision of the patella is indicated for all comminuted fractures involving a major portion of the patella and for those rare fractures involving only the upper pole; it is rarely contraindicated. (iv) Good results cannot be assured by any method if there is a preexisting disability or severe concomitant injury, but patellectomy does offer the best opportunity for a good result. (v) The period of disability is approximately half as long after patellectomy as after other methods of treatment.

The Mid-Line Incision for Biliary Tract Surgery.

Horace G. Moore, junior (*Surgery*, March, 1954) states that the upper mid-line incision has been used for gastric resection in his hospital for the past five years. Occasionally cholecystectomy has been performed for coincidental disease of the gall-bladder at the same time. It was noted that exposure of the cystic duct, cystic artery and common bile duct was excellent through the mid-line incision. With this experience in mind a policy was deliberately instituted of using the upper mid-line incision for cholecystectomy and for exploration of the common bile duct. The incision has been used in 48 cases; and in all instances the surgeons have been pleased with the exposure, regardless of the patient's degree of obesity or the size of the costal angle. The author has found that, in addition to the excellent exposure, ease and speed in opening and closing the abdomen are advantages.

The Diagnosis of Synovial Tuberculosis by Gland Biopsy.

Simon Sevitt (*Brit. J. Surg.*, January, 1954) states that primary tuberculous disease of the lymph glands of the upper or lower limbs is exceptional, but secondary tuberculosis of the lymph glands draining a tuberculous focus is common. For example, the inguinal glands of the same limb in a patient with tuberculosis of the knee are usually enlarged and tuberculous. Although this secondary tuberculosis of the lymph glands has been known for many years, the biopsy of a regional lymph node as an aid to diagnosis of tuberculosis in its drainage area was not described until 1933 by Valls. In 1939 Seddon described a series of 18 patients with tuberculosis of the knee joint. Biopsy of the ipsilateral inguinal glands of these patients was carried out, and in 15 of the 18 the glands were found to be tuberculous. The author states that tuberculous infection of the synovial membranes of the hand and wrist is not an uncommon condition, and occasionally the diagnosis is difficult. Eight cases are listed and described. Epitrochlear lymph gland biopsy was carried out in all cases, and synovial tissue was removed and examined in each instance. The findings were consistently accurate, and, although the series is small, the author recommends the method as reliable.

Radiography of Cysts of the Breast.

J. Gershon-Cohen and Helen Ingleby (*Surg., Gynec. & Obst.*, October, 1953) present an interim report of the results of a study of cysts occurring in a series of 650 consecutive patients examined radiologically at the Albert Einstein Medical Centre. They state that the method merits increasing recognition in the diagnosis of all mammary disorders. The history of sudden onset of a large mass, freely movable, often tender and painful, is in itself diagnostic of cysts. A similar albeit smaller mass in the opposite breast lends diagnostic confirmation. Certain non-cystic conditions may mimic a cyst very closely, namely, fibroadenoma, abscess and adenosis. X-ray examination is of value if properly evaluated with clinical information. Rarely have the authors observed cysts in patients under twenty-five years of age, and a cyst arising after the age of fifty-five years should be regarded with suspicion. Cysts may vary in size from microscopic dimensions to those occupying a large segment of the breast, but only those of a diameter more than 0·5 centimetre can be seen in an X-ray film. In a satisfactory film, they appear as well-defined opacities with a smooth outline. There is little difference in the degree of density between cysts and the breast parenchyma, but the uniform density of a cyst helps to distinguish it from the trabecular structure of the breast tissue. The density of cysts varies somewhat with their contents. It would appear that cysts of the breast can be demonstrated in X-ray films. The more fat in a breast, the easier is the demonstration. Conversely, the more compact and dense the parenchyma, the more difficult is the diagnosis.

Ruptured Aortic Aneurysm: A Surgical Emergency.

F. Gerbode (*Surg., Gynec. & Obst.*, June, 1954) briefly discusses aortic aneurysms and draws attention to the fact that fatal rupture is frequently preceded by repeated episodes of pain or mild shock extending over a period of days or weeks. The symptoms mean that the aneurysm is expanding, pressing upon adjacent structures or rupturing. If the dissection occurs posteriorly, the pain is in the back; whereas, if it is anterior, the signs and symptoms are those of peritoneal irritation. There may thus be time to prepare for surgical intervention, and cases referred to show that resection of the diseased portion of the abdominal aorta with replacement by a homograft is possible with a low mortality. In one case the operation was successful even after massive hæmorrhage had resulted from a large rupture.

Anticancer Agents.

J. R. Sampey (*Am. J. Surg.*, June, 1954) surveys the published clinical studies on anticancer agents from 1949 to 1951. He states that radioactive isotopes continue to be the most used inorganic chemical agents for the treatment of cancer. Carcinoma of the thyroid may be treated successfully with radioiodine. Other isotopes used include radiophosphorus for the treatment of chronic leuchæmia, radiosodium for the treatment of carcinoma of the bladder, and radiogold for the treatment of ovarian carcinoma and peritoneal metastases. The nitrogen mustards remain the most important chemotherapeutic agents for the treatment of neoplasms, including Hodgkin's disease, adenocarcinoma and lymphosarcoma. Urethane has been used in a variety of neoplastic diseases. Folic acid antagonists have been used extensively as antileuchæmic agents. Many reports of the use of androgens and of œstrogens for carcinoma of the breast and of œstrogens for carcinoma of the prostate have appeared. ACTH and cortisone are being used more extensively in the treatment of leuchæmia, Hodgkin's disease, lymphosarcoma and multiple myeloma.

Cancer of the Stomach.

George T. Pack (*Surgery*, June, 1954) describes two cases of cancer of the stomach in which the subjects have survived more than twenty years after operation. In the first case, in which the first gastrectomy for cancer was performed in the newly organized gastric service of the Memorial Hospital, New York, a gastro-enterostomy was later followed after twelve weeks by a Billroth II type of gastrectomy. The pathologist's report stated that the condition was tubular adenocarcinoma, the tumour extending throughout the thickness of the stomach wall and growing in the serosa. In this case symptoms had been present for sixteen months, but in the second an asymptomatic gastric cancer was found on routine X-ray examination. After resection of a polypoid adenocarcinoma, Grade II, the patient has also remained alive and free of any evidence of recurrence.

Leiomyosarcoma of the Inferior Vena Cava.

J. S. Cope and C. J. Hunt (*Arch. Surg.*, June, 1954) report what is apparently the first case of leiomyosarcoma of the inferior *vena cava* in which treatment by operation was successful. The patient, aged thirty-three years, had complained of pain in the lumbar region for eighteen months. Examination revealed a mass measuring about four by five centimetres above and to the right of the umbilicus. At operation the tumour was found to be arising from the inferior *vena cava*, and this was resected from a point just inferior to the renal veins down to the iliac veins. Post-operatively, some œdema of both legs appeared on only the fifth day. The pathologist confirmed the diagnosis of leiomyosarcoma of the

inferior *vena cava*. Sixteen months later a tumour measuring three by three centimetres and arising from the inferior wall of the right renal vein was removed, together with the right kidney and vessels. After a further thirteen months two tumour masses, one two centimetres and the other three centimetres in diameter, were found firmly attached to the stump of the right renal artery but quite separate from the stump of the inferior *vena cava*. In the six months since then the patient has remained well.

Abdomino-Perineal Resection with Sphincter Preservation.

J. W. WAUGH, E. M. MILLER AND F. T. KURZWEG (*Arch. Surg.*, April, 1954) describe the technique and results of abdomino-perineal resection with sphincter preservation for carcinoma of the mid-rectum. Over a period of six years 165 patients submitted to this operation, which consists of mobilizing the rectum from above and then dissecting out the anal canal from the underlying external sphincter muscles and from the *levator ani* muscle. When the mobilization is complete, the rectum and lower part of the sigmoid are drawn down through the sphincteric orifice and then excised over a Payr clamp, which has been placed so as to allow an inch segment of viable bowel to protrude beyond the perianal skin. The bowel is anchored by suturing fat tags to the perineal skin. Six hospital deaths occurred (3·6%). The authors state that of 52 patients who underwent operation five or more years ago, there are seven in whom the operation was obviously only palliative. Of the remaining 45 patients 23 have survived for at least five years. The degree of continence obtained post-operatively has been classed as excellent in 10% of cases, good in 42%, fair in 25% and poor in 23%.

Surgical Pathology of the Colonic Stoma.

GUY L. KRATZER (*Surg., Gynec. & Obst.*, January, 1954) discusses the numerous complications which may develop in spite of all precautions in the colonic stoma. Retraction of the colonic stoma is usually due to the early removal of the retaining clamp or other support before healing has taken place, or to insufficient mobilization of the bowel. The bowel, if it is to be a single barrel stoma, should extend for a distance of at least one and a half inches above the skin surface without undue tension and be held in that position by a clamp for at least eight days. If a loop colostomy is planned, such position should be maintained for a period of at least two weeks. If a patient is seen after retraction has taken place, usually several weeks or months after operation, a minor plastic procedure to elevate the bowel is necessary. Contraction of the colonic stoma is prevented by adequate opening of the bowel and the use of dilatation. Prolapse of a colonic stoma is predominately a complication of double-barrelled colostomy. One may usually prevent such a development by bringing out a loop of bowel in such a manner as to have the proximal limb under slight tension. It is admitted that this procedure is difficult in performance of transverse colostomy because of the mobility of this segment of the colon. Appliances used for collecting the bowel discharges will tend to produce prolapse because of the vacuum created. The more severe type with danger of torsion and strangulation needs surgical treatment. Herniation of the muscles immediately surrounding the colonic stoma follows wound infection and operations on patients with inherently weak abdominal walls or with general obesity. Fistulæ may result from stitches in the bowel wall and the insertion of catheters and other trauma early in the post-operative course. Ulceration and hæmorrhage occur as a result of trauma. Fæcal impaction is more apt to occur in a double-barrelled stoma. Proper bowel hygiene may prevent the occurrence. Herniation of a loop of small bowel along the side of the colonic stoma is a rare complication. Intestinal obstruction requiring immediate laparotomy may be precipitated by a loop of small bowel caught in the space between the colonic stoma and the parietal peritoneum. Such a space should be closed at the time of surgery.

The Bone Cysts of Osteoarthritis.

J. W. LANDELLS (*J. Bone & Joint Surg.*, November, 1953) states that previous investigators had found cysts in 32 out of 242 cases of osteoarthritis of the hip. The presence of cysts is often indicated by severe pain in the joint. Subsequently, in cases selected for surgical treatment of osteoarthritis, cysts were found to be neither so rare nor so incidental as suggested previously. They have been present in 11 of the last 19 heads of the femur and in one of the last three patellæ excised for osteoarthritis. The cysts are usually multiple and surrounded by a zone of dense bone up to half a centimetre thick. It was noted that small cysts were found in the subchondral bone, and large cysts extended more deeply. The author states that if the cysts were due to bone degeneration, small early foci would be found on routine examination of the deep bone; but such foci were not found, nor are they described in the literature. The bone surrounding the cysts is always more or less sclerotic, and often shows active bone formation, a sequence of changes difficult to account for as a degeneration. Moreover, it is unusual to find areas of osteoclastic resorption in the wall of the cysts, and when they occur they affect only a small part of the circumference. The cartilage over the cysts is never normal, though the stage of its degeneration varies from quite early vertical splitting to complete erosion. The cysts are not found in eburnated bone, probably because of its rigidity, and because the marrow spaces in such bone are sealed off from the joint cavity by new bone formation; but cysts with a vent in the cartilage at the side may burrow extensively under eburnated bone. The hypothesis is advanced that the cysts are formed by the intrusion of synovial fluid under pressure into the substance of the bone, sclerosis around any displacement of the trabeculæ and reinforcement by new bone. The author considers that the penetration of synovial fluid is likely to occur in the regions where the cysts are found, and sometimes there is visual proof that it has occurred. With a persistent opening the uniform fluid pressure tends to convert the irregular outlines of the marrow spaces into the smoothly rounded or pyriform outlines characteristic of the cysts, with the narrow end of the cyst towards the joint space where expansion is limited by the strong articular lamella. Around this pressure zone is dense bone formed partly by bodily displacement of the trabeculæ, partly by new bone formation in response to the strain. Such sclerosis around the cysts is one of their most conspicuous features, and one most hard to explain on a hypothesis of degeneration. The larger cysts are almost confined to the head of the femur; elsewhere it is unusual for them to reach a diameter of a centimetre. The rounded outlines suggesting fluid pressure, the increase of synovial fluid in osteoarthritis, the pressure built up in the hip by the weight of the body, the extremely tough capsule of that joint compared with that of the knee and the clinical relationship between painful hips and cystic bone changes form a chain of evidence of some strength in favour of the hypothesis that these large cysts are virtually internal incomplete fractures of the bone brought about by the slow persistent transfer of pressure from the synovial fluid to the weak internal cancellous trabeculæ unaccustomed to such lateral thrusts.

Complications Following the Use of "Efocaine".

DANIEL C. MOORE (*Surgery*, January, 1954) states that "Efocaine" has been widely used and has been reported on favourably in the literature and at medical meetings. The drug has been well advertised, and lay people now know about it as a drug which will render the post-operative period free from pain. The author and his associates have performed intercostal nerve blocks for post-operative pain in over two thousand patients, using one of the common local anæsthetics, "Pontocaine" (tetracaine) hydrochloride. Until they started using "Efocaine" they did not encounter intercostal neuritis or paralysis following the blocks. Of the 41 patients who received an intercostal injection of "Efocaine" for post-operative pain, the majority were free or partially relieved of pain, but nine did develop severe intercostal neuritis. At first three millilitres of "Efocaine" were used to each intercostal space, but then the dose was reduced to not more than two millilitres under any one rib. All nine patients developed their pain about fourteen days after the injection, and the neuritis lasted six weeks before disappearing in some cases. Four documented cases of transverse myelitis with varying degrees of paralysis were accumulated from the literature, and the author gives the detail of the four cases. It is suggested that the solution placed inches away from the spinal cord causes the transverse myelitis by the tracking of the solution up the perineural spaces to the spinal cord. In addition to transverse myelitis and intercostal neuritis from "Efocaine", cellulitis and sloughs have been noted, and cases of these and of abscess are cited. The author suggests that before injection of "Efocaine" it is best to consider this question: When a drug or mixture is capable of producing transverse myelitis, intercostal neuritis or a tissue slough, should it be used routinely for patients whose pain is only temporary in nature (for example, post-operative pain) and in whom surgery for a curable disease such as diaphragmatic hernia is being performed?

British Medical Association News.

MEETING OF THE FEDERAL COUNCIL.

A MEETING of the Federal Council of the British Medical Association in Australia was held at the B.M.A. Building, 225 Wickham Terrace, Brisbane, on August 30 and 31 and September 1, 1954, DR. A. J. COLLINS, the President, in the chair.

Minutes.

The minutes of the Federal Council meeting of March 15, 16, 17 and 18, 1954, which had been circulated among members, were taken as read and signed as correct.

Representatives.

The following representatives of the Branches were present:

New South Wales: Dr. A. J. Collins, D.S.O., M.C., Dr. W. F. Simmons, Dr. H. R. R. Grieve, Dr. A. J. Murray, O.B.E.

Queensland: Dr. A. E. Lee, Dr. H. W. Horn.

South Australia: Dr. L. R. Mallen, Dr. C. O. F. Rieger.

Tasmania: Dr. L. N. Gollan, Dr. Melville Kelly (as proxy for Dr. J. G. B. Muir).

Victoria: Dr. H. C. Colville, Dr. Charles Byrne, Dr. Robert Southby.

Western Australia: Dr. D. E. Copping, Dr. C. W. Anderson.

The President, Dr. A. J. Collins, welcomed Dr. Melville Kelly to the meeting.

Finance.

The financial statement of the Federal Council as at August 30, 1954, was presented by Dr. W. F. Simmons, the Honorary Treasurer, and adopted. Dr. Simmons pointed out that the finances of the Federal Council were in a healthy condition. He set out an estimated amount of the expenses likely to be incurred up to December 31, 1954. He thought it very probable that another meeting of the Federal Council would be held before the end of the year, and that would be the third meeting for 1954. He thought that the next meeting would probably be held at Sydney as it was Sydney's turn for a meeting, and then the first meeting in 1955 would be held in Melbourne. In the budget was included a large sum for the payment of the expenses of the Federal Council's delegate to the meeting of the World Medical Association at Rome in September, 1954, together with those of Dr. L. R. Mallen, who would attend the meeting in Rome as a member of the Council of the World Medical Association, but whose expenses for the duration of the General Assembly would be met by the Federal Council. This arrangement had been arrived at at a previous meeting of the Council. Dr. Simmons also reminded the Council that it was necessary to have in hand a certain amount of money in case a suitable appointee should be discovered for the position of assistant to the General Secretary.

Dr. Simmons presented a statement setting out the per capita payments of the Branches for the year 1954, and he expressed the opinion that the capitation fee for the year 1955 should be 21s. per member. The Federal Council adopted Dr. Simmons's suggestion.

Dr. Simmons then presented a statement showing the position of the Organization Fund for the period ended August 25, 1954. The amount standing to the credit of the fund was £1923.

Dr. Simmons presented a statement setting out the position of the Federal Independence Fund as at August 25, 1954. He also showed a statement in which were included the amount of refunds which had been requested by donors in connexion with the funds. After these refunds had been made the amount standing to the credit of the fund was £20,713.

The Henry Simpson Newland Prize Fund in Surgery.

Dr. W. F. Simmons, the Honorary Treasurer, presented a statement dealing with the Henry Simpson Newland Prize Fund. He said that the amount standing to the credit of the fund was £1100 8s. 7d.

At the previous meeting of the Federal Council Dr. H. C. Colville had been asked to secure a design for the medal which was to be struck in connexion with the prize. Dr. Colville presented to the meeting drawings for the medal. On one side was a bas-relief of the head of Sir Henry Newland and on the other was a design stating that the medal was the Henry Simpson Newland Prize Medal and that it was established by the Federal Council of the British Medical Association in Australia. In the centre was the serpent of Æsculapius. Dr. Colville explained that the cost of the die would be 200 guineas and that each medal struck would cost three guineas.

The Federal Council approved of the design and thanked Dr. Colville for his services in the matter. Dr. W. F. Simmons explained that the sum for the making of the die would have to be paid out of the funds of the Federal Council, and he moved a motion to this effect which was carried.

The Medical Officers' Relief Fund (Federal).

On behalf of the trustees of the Medical Officers' Relief Fund (Federal), Dr. W. F. Simmons, the Honorary Treasurer, presented the interim report for the six months ended June 30, 1954. He explained that the amount to the credit of the fund was £7419. Two beneficiaries had died during the previous six months and two widows only were now receiving help from the fund. The report was received and adopted.

Federal Medical War Relief Fund.

On behalf of the trustees of the Federal Medical War Relief Fund, Dr. W. F. Simmons presented an interim report for the six months ended June 30, 1954. He explained that the amount standing to the credit of the fund was £19,205. Help was being given to eleven beneficiaries. Four of these beneficiaries lived in New South Wales, five in Victoria, one in Queensland and one in South Australia. The money was being mainly used in the education of children. Dr. Simmons explained that the South Australian Branch had contributed £56 to the fund and also that the Illawarra Local Medical Association in New South Wales had donated to the fund a sum of money which had been left over from the fund established in the Illawarra district to help practitioners to maintain their practices while they were on active service in the last war. He said that some members who had given money to the Independence Fund had asked that their contributions be transferred to the Federal Medical War Relief Fund. The report was received and adopted.

Honours.

The General Secretary reported that on behalf of the Federal Council he had offered congratulations to the following who had been honoured by Her Majesty the Queen: Sir Alexander Paterson Murphy, K.B., Sir Herbert Henry Schlink, K.B., Dr. Arthur John Metcalfe, C.B.E., Dr. Cecil Julian Manning Walters, C.B.E., Dr. Robert Stanley Steel, O.B.E., Dr. Douglas William Leigh Parker, O.B.E.

Congratulations.

The General Secretary reported that he had sent congratulations to Sir Macfarlane Burnet on his receiving the award of the von Behring prize of the University of Marburg, and had also congratulated Air Vice-Marshal E. A. Daley on his appointment as Vice-President of the Aero Medical Congress at Washington, United States of America.

Inquiries from Overseas About Medical Practice in Australia.

The General Secretary reported that he had as usual received several inquiries from medical practitioners overseas in regard to the conditions of practice in Australia. He had sent suitable replies.

Inquiries from South Africa About Income Tax Deductions in Australia.

The General Secretary reported that he had received from the Medical Association of South Africa inquiries in regard to income tax deductions allowed to medical practitioners in Australia in respect of post-graduate studies. He had given the necessary information and pointed out that deductions were allowed only if the post-graduate work was undertaken in order to maintain efficiency. No deductions were allowed if the post-graduate student sought and obtained an extra degree or diploma. A further hardship was that no income tax deductions were allowed for post-graduate study if the practitioner concerned was an employee of any medical association or other body.

International Federation of Medical Students Associations.

The General Secretary reported that he had received advice that the International Federation of Medical Students Asso-

ciations would hold an assembly at Rome on October 1 to 5, 1954.

World Congress of Cardiology.

The General Secretary reported that he had received advice from The Royal Australasian College of Physicians to the effect that the Second World Congress of Cardiology and the 27th Annual Scientific Session of the American Heart Association was to be held at Washington, United States of America, from September 12 to 17, 1954. He had passed the information on to the Branches.

Inquiries from Germany About Workers in Poliomyelitis.

The General Secretary reported that he had received from the Embassy of the Federal Republic of Germany an inquiry about the names and addresses of Australian scientists who were engaged in research work in poliomyelitis. The information had been forwarded and the correspondence had been sent to the Branches.

Complaint from Western Australia About Medical Registration.

The General Secretary reported that he had received from Dr. J. J. O'Connor a letter complaining of the action of the Medical Board of Western Australia in fining him for failure to effect his registration by an appointed date. Dr. O'Connor had been referred to the Western Australian Branch, and it had been pointed out to him that the law in Western Australia regarding registration was quite definite in its provisions that unless registration was secured by a certain date of which the members of the profession had been notified, a fine would be imposed.

Australasian Medical Congress (British Medical Association).

Ninth Session.

The General Secretary reported that he had sent an invitation on behalf of the Federal Council to His Excellency the Governor-General of Australia, Field Marshal Sir William Slim, inviting him to become Patron of the Ninth Session of Congress which was to be held at Sydney from August 20 to 27, 1955. The Governor-General had replied that he was not in a position to say whether he would be able to accept the invitation or not. His programme for 1955 was not yet complete.

The General Secretary reported that vice-presidents had been appointed as follows: from the Queensland Branch, Dr. H. S. Patterson; from the Western Australian Branch, Dr. B. W. Busworth; and from the New Zealand Branch, Dr. J. O. Mercer. Invitations to accept the position of vice-president had been sent by the Federal Council to Sir Henry Newland, Sir Victor Hurley, Sir Alexander Murphy, and Dr. D. M. McWhae, Air Vice-Marshal E. A. Daley, Dr. A. J. Metcalfe and Dr. John Cairney. All the seven had accepted the nominations.

The Secretary reported that Dr. T. C. Routley, who had consented to deliver the Henry Simpson Newland Oration at the Ninth Session of Congress, had written regretting his inability to accept the invitation. A discussion took place on possible orators, and it was decided that an invitation should be extended to Dr. Louis Bauer, of New York. Dr. Bauer was a past president of the American Medical Association. He was General Secretary of the World Medical Association and had held other positions of importance in the medical world.

The minutes of the Executive Committee held in February, April, May, June and August, 1954, were laid on the table.

The General Secretary reported that he had had correspondence with overseas associations inviting them to send delegates to the Ninth Session.

Australasian Medical Publishing Company, Limited.

The General Secretary reported that he had received from the Queensland Branch a letter suggesting that the directors of the Australasian Medical Publishing Company, Limited, should be asked to make arrangements so that members of the Association living either temporarily or permanently outside Australia could obtain THE MEDICAL JOURNAL OF AUSTRALIA by an increase in their subscription equivalent to the increment of the British Medical Association subscription in Australia which provided members with the *British Medical Journal*. The letter had been sent to the Branches and replies had been received. The New South Wales Branch did not approve of the proposal of the Queensland Branch. The Victorian Branch left the matter in the hands of its delegates. The South Australian Branch thought it was desirable that a concessional rate should be made with the supply of THE MEDICAL JOURNAL OF AUSTRALIA to members of the Association who lived either temporarily or permanently outside Australia. The Western Australian Branch supported the suggestion of the Queensland Branch. The Tasmanian Branch thought that the matter should be referred to the Australasian Medical Publishing Company, Limited. Dr. A. E. Lee put before the Federal Council the views of the Queensland Branch. He explained that when young graduates went abroad they often transferred their membership to some centre in England where they were residing temporarily and it would be an advantage to them if they could receive THE MEDICAL JOURNAL OF AUSTRALIA without having to pay on the full membership fee of the Australian Branch from which they came. Dr. Lee moved that the matter should be brought to the notice of the directors of the company who would be holding their meeting on October 13, 1954. The motion was carried.

Medical Planning.

National Health Service: National Health Act, 1953.

The General Secretary drew the attention of the Federal Council to the dates on which the various parts of the *National Health Act* of 1953 had been proclaimed. The last section had been proclaimed on May 12, 1954.

The General Secretary also explained that an informal discussion had been held with the Minister for Health on August 30, 1954.

The Federal Council had before it a letter from the New South Wales Branch in which it was stated that complaints had been received from local associations and from individual members of the profession which showed that there was intense and widespread dissatisfaction at the manner in which the profession had been advised of the introduction of the National Health (Pharmaceutical Benefits) Regulations. It was pointed out in the letter that the success of any National Health Scheme depended largely on the cooperation of the profession as a whole and of its individual members, and that such cooperation was likely to be adversely affected in the event of any similar happenings in the future. With a view to ensuring the continued cooperation of the profession, the New South Wales Branch asked the Federal Council that it should seek an assurance from the Minister of Health that no major changes would be made in the national health service without prior consultation with the profession, and that no important changes would be made until the practising profession had had adequate warning of their nature. The General Secretary said that he had sent this letter to the Branches. The Queensland Branch had agreed with the letter of the New South Wales Branch. The Victorian Branch supported the view expressed by New South Wales. The South Australian and Western Australian and Tasmanian Branches also agreed with the New South Wales views. The General Secretary said that the views of the Branches had been communicated to the Minister of Health. The Minister had explained the difficulties under which the Regulations had been introduced in the last stage of the parliamentary session just before the recent elections and he gave an assurance that in future he would give the profession adequate notice of impending alterations. The Federal Council also had before it a copy of a letter addressed to Dr. Byron L. Stanton by the Secretary of the Victorian Branch of the British Medical Association and the Secretary of the Pharmaceutical Society of Victoria. In this letter it was stated that the Victorian Medico-Pharmaceutical Liaison Committee had discussed certain aspects of the new Pharmaceutical Benefits Regulations on June 10, 1954. The committee wished Dr. Stanton to bring the matter before the Advisory Committee established under the *National Health Act*, which was to meet on June 18, 1954. It was stated that the medical and pharmaceutical representative at the meeting on June 10 had reported that there was widespread dissatisfaction and resentment throughout the State at the manner in which the new regulations had been promulgated. The committee had recommended that the Federal Council of the British Medical Association in Australia and the Federated Pharmaceutical Service Guild should be asked to make their strongest representations to the Minister of Health at any future changes in the regulations, and the list of benefits should not be introduced without prior consultation with representatives of the official medical and pharmaceutical organizations. The committee thought that the department should be pressed to give all members of both professions at least one month's notice of impending changes.

The Federal Council had before it a letter from the New South Wales Branch with regard to the National Health (Pharmaceutical Benefits) Regulations. The letter stated that under the regulations a medical practitioner was not

to prescribe both a general pharmaceutical benefit and a pensioner pharmaceutical benefit on the one prescription form. The Branch thought that with a view to helping to reduce both the amount of writing which a medical practitioner was called upon to do and the time involved, the Federal Council should make representations to the authorities to amend the regulations so that prescriptions for both types of benefit should be written on the one form. The General Secretary said that he had referred this matter to the Branches. The Queensland Branch had pointed out that as the two classes of benefit were made from different funds, the New South Wales Branch's suggestion was impracticable. The same view was expressed by the Victorian and South Australian Branches. The Western Australian and the Tasmanian Branches agreed with the New South Wales suggestion. In discussion, Dr. H. C. Colville pointed out that two different departments were involved and the Victorian representatives could not support the suggestion. A motion embodying the New South Wales suggestion was negatived.

A communication was received from the New South Wales Branch asking that representations should be made to the Minister of Health to have the Regulations amended so as to provide: (*a*) that the doctor's signature on the back of a prescription should be sufficient endorsement on the back of the prescription for pharmaceutical benefits. The Branch also pointed out that where the duplicate of a prescription was not a carbon copy the word duplicate was inserted; it was thought that it was not necessary to insert the word duplicate in a carbon copy. On the motion of Dr. W. F. Simmons, resolutions embodying these three points were adopted.

Dr. Charles Byrne referred to the maximum dose of penicillin which could be used in one day. The reduction of the amount which had recently been made was, he said, a hardship and a great inconvenience to medical practitioners. All medical practitioners were agreed that the permissible amount to be prescribed should be increased. On the motion of Dr. M. Kelly, seconded by Dr. H. W. Horn, the Federal Council resolved that representations should be made to the Director-General of Health that the original doses and quantities of penicillin should be restored.

Pensioner Medical Service.

At the previous meeting of the Federal Council a discussion took place in regard to the liberalization of the means test and its effect on the Pensioner Medical Service. At that meeting the Federal Council had resolved that the Minister of Health should be informed that its representatives would be prepared to discuss with him any alternative form of medical service which he might propose for the nucleus of pensioners made eligible by future liberalization of the means test. The Federal Council had appointed a committee which was to confer with the Minister should this become necessary.

The Federal Council had also resolved that the Branches should be asked to define the policy which should be adopted in regard to the Pensioner Medical Service in the event of the liberalization of the means test. The Federal Council decided that in particular the Branches should be asked to give consideration to the following questions:

1. In the event of new categories of pensioners being introduced after 31st March, 1954, should this result (*a*) in a complete reconsideration of medical service for pensioners; or (*b*) a general rise in the payment for pensioner medical services; or (*c*) should a new form of provision of medical services be introduced for these new groups?

2. If a new form of medical service is to be provided for these groups, should this be by: (*a*) an increased rate of medical payment for these groups; or (*b*) the Government paying the premium for members joining medical benefit funds of their own choice; or (*c*) should they be excluded from the pension medical service; or (*d*) any other alternative?

The General Secretary reported that replies had been received from the Branches. The New South Wales Branch had replied that any discussions with the Federal Government in connexion with the Pensioner Medical Service and the liberalization of the means test should be on the basis that the present system should be retained for those pensioners who could satisfy the existing means test. Pensioners who as a result of the liberalization of the means test would become entitled to pensioner benefits but would be unable to satisfy the existing means test, should receive their services as members of the medical benefit organizations. With regard to the fees to be charged to those who would receive their services as members of medical benefits funds, it was considered that these should be on the basis of private fees. The Victorian Branch had replied as follows: (i) The Federal Council should be informed that in the event of new categories of patients being introduced after March 31, 1954, the Branch Council was of the opinion that this should lead to a complete reconsideration of the medical service for pensioners. (ii) The Branch Council disapproved of a general rise in the payment for Pensioner Medical Service as a sole solution of the problem which would follow the introduction of new categories of pensioners. (iii) The Branch Council considered that if a new form of medical service was to be provided, the following principles should apply: (*a*) that pensioners should be incorporated in the general medical benefit scheme for purposes of obtaining medical service; (*b*) that the medical profession should no longer be expected to provide such service on a concessional basis. The South Australian Branch had replied that its Council was of the opinion that in the event of new categories of pensioners being introduced after March 31, there should be a complete reconsideration of the present arrangement providing medical services to pensioners. The Branch added that on the assumption that it was impossible for the Government to differentiate between two different categories of pensioners, it was of the opinion that the Government should evolve a scheme by which all pensioners were absorbed into the medical benefit scheme. The South Australian Branch fully realized that there were many difficulties inherent in the absorption of pensioners into medical benefit schemes; however, in spite of the fact that very careful consideration had been given to the matter, no other alternative could be suggested. The Western Australian Branch had expressed the opinion that by the liberalization of the means test the Pensioner Medical Service agreement automatically lapsed and that the Federal Council should negotiate new terms of agreement. The Tasmanian Branch replied that the whole scheme should be reviewed and that in the event of the admission of new categories of pensioners, it should be a recommendation to the Federal Council that the present Pensioner Medical Service scheme be reviewed and that this should take the form of a general all-round increase in fees for treatment. The Queensland Branch had replied that in its opinion a service similar to the present service should be continued. It thought that the terms of service should be 9s. per consultation at the doctor's surgery and 12s. for each domiciliary visit. It also expressed the opinion that in the event of new categories of pensioners being established, the previous resolution that new categories should not be received into the Pensioner Medical Service should be reaffirmed.

In the discussion which followed reference was made to the fact that the Prime Minister in his policy speech had declared that all pensioners would be entitled to a free medical service. This meant that some 50,000 or more persons would be brought within the Pensioner Medical Service. The Federal Council was reminded that the members of the medical profession had declared that in no circumstances would they accept further categories of persons on the present Pensioner Medical Service. According to the arrangements under which the Pensioner Medical Service was conducted, the agreement between the medical profession and the Government would terminate on December 31, 1954. It seemed as though an impasse had been reached. The Federal Council appeared to be unwilling that such an important service as that being provided to pensioners in Australia should cease. After a discussion the Federal Council appointed a subcommittee consisting of Dr. H. R. R. Grieve, Dr. A. E. Lee, Dr. Charles Byrne, Dr. C. O. F. Rieger and Dr. C. W. Anderson to examine the future of the Pensioner Medical Service with a view to submitting a concrete proposal to the Council. The committee met and at a later stage in the meeting submitted a short report. In this report it was stated that the whole question had three antecedent factors. In the first place the problem had arisen without prior consultation with the medical profession. Secondly, further categories of pensioners could not be admitted to the privileges of the present Pensioner Medical Service unless the proportion of a doctor's income derived from government sources was to reach a point at which economic pressure might compel him to accept progressively higher income groups, thus encompassing his complete nationalization. Thirdly, experience of the National Medical Service so far had proved to competent authorities that the only effective preventive of abuse was the obligation of the patient to pay a fraction of the medical fee. The report of the committee concluded with the following statements:

1. The profession is prepared to carry on the Pensioner Medical Service for those categories of pensioners qualified under the conditions existing on 31st March, 1954.

2. For all additional categories of pensioners the profession advises that medical service should be provided by medical benefit organizations under the following conditions:

(a) The premium of the pensioner shall be paid by the Government.

(b) The premium may be directed towards providing: (i) the full cost of a general practitioner consultation and domiciliary service of the scope of the present Pensioner Medical Service; or (ii) a portion of the premium of any other medical benefit schedule which the pensioner may elect to join. In neither case shall the benefit organization apply probationary period or exclusions of pre-existing illnesses, but in each case 90% maximum benefit clause shall operate.

(c) Any member of the Pensioner Medical Service may elect to exchange this service for the medical benefit service.

(d) It is proposed that the new schedule will provide combined benefits of 13s. 6d. per consultation and 15s. per visit, and it is anticipated that such a service could be provided for no more than ninepence per person per week. Since it is believed that the necessity of some direct payment would diminish the number of services per person compared with that of the present Pensioner Medical Service, the probable cost to the Government should be approximately the same as the Pensioner Medical Service.

The Federal Council adopted the report of the committee. After further discussion it was resolved that the question of the Pensioner Medical Service together with all available information should be referred to the Branches for their consideration. It was also resolved that the proposals set out in the report of the committee should be embodied in a letter to the Minister of Health, and that he should be asked to arrange for an interview with the Prime Minister. The Federal Council resolved that if such an interview took place the President should be empowered to discuss with the Prime Minister all aspects of the problem of the Pensioner Medical Service.

The Federal Council had before it a list of drugs which had been sent to every practitioner in New South Wales. The list had been compiled at the request of the Medical Pharmaceutical Liaison Committee for the convenience of medical practitioners in prescribing the Pensioner Pharmaceutical Benefits. The list was noted.

The General Secretary read a letter which he had received from the Federated Pharmaceutical Guild of Australia. In this letter which was dated June 2, 1954, the attention of the Federal Council was directed to two references appearing in THE MEDICAL JOURNAL OF AUSTRALIA of December 19, 1953, and April 17, 1954. In both issues of the journal reference had been made to the President of the Federal Council of the Pharmaceutical Society of Australia in relation to aspects of the National Health Service. The Federal Executive of the Guild informed the Federal Council that it was the sole negotiating authority upon all matters concerning members of the Associated Pharmaceutical Organizations of Australia in relation to the service. This authority to negotiate with the Commonwealth Government on behalf of the pharmaceutical profession had been recognized in the *National Health Act*, 1953. The letter was noted.

A letter was received from the Western Australian Branch drawing attention to a ruling of the Deputy Director of Health of Western Australia to the effect that dienœstrol was not available as a pensioner benefit and asking that urgent representation should be made to the Minister of Health for its restoration as a pensioner benefit. It was pointed out that dienœstrol could be prescribed as a pensioner benefit even though it was not listed as a pharmaceutical benefit.

A letter was received from the Victorian Branch recommending that regulation 19 (1) (a) should be amended so as to provide that prescriptions in the handwriting of the medical practitioner or the person associated with him in the conduct of his practice might be accepted provided the prescription was signed by the practitioner himself. It was pointed out that in certain cases such as those associated with the prophylactic injection of diphtheria antitoxin, the practitioner was often called upon to write as many as 30 to 40 prescriptions in his own handwriting and this was considered to be a hardship. It was thought that if the nurse in the doctor's rooms wrote the prescriptions for him and he signed the prescriptions this should be acceptable. A motion in accordance with the recommendation of the Victorian Branch was put to the Federal Council and negatived.

The General Secretary said that he had written to the Director-General of Health in regard to the simplification of voucher forms in connexion with the Pensioner Medical Service. The request was made that in view of the fact that the pensioner's number was indicated on the voucher form consideration should be given to the deletion of his address. A reply had been received from the Director-General stating that it was not possible to accede to the Federal Council's request. Experience had shown that as a result of errors in quoting pension numbers on voucher forms the pensioner's address became essential for establishing a pensioner's identity, more particularly when two or more pensioners bore the same name. Addresses also provided a useful means of detecting frequent attendances at the same address such as an institution, nursing homes and the like. Further, they provided a necessary eligibility check when interstate pensioners were concerned or duplication of vouchers was suspected. The Director-General thought that the Federal Council would appreciate that it was essential for pensioner's addresses to be quoted on all mileage vouchers and on the related domiciliary vouchers so that mileage fees might be properly computed. The Director-General added that the Federal Council was no doubt aware that when a medical practitioner's claim included more than one voucher for a pensioner, the pensioner's address might be omitted from the second and subsequent vouchers.

Further reference was made to the payment of mileage rates in connexion with the Pensioner Medical Service. The General Secretary said that he had written to the Director-General of Health in December, 1953, asking for a variation of the mileage arrangement in the Pensioner Medical Service. He had received a reply from the Director-General stating that the proposal submitted by the Federal Council had been very carefully considered by officers of his department, including deputy directors of health in the various States who were concerned with the application of the existing mileage rates. It had subsequently been discussed with the Minister of Health. After full consideration the Minister had decided that he was unable to agree to a variation of the mileage rates as proposed by the Federal Council. After discussion the Federal Council resolved that a further approach should be made to the Minister in the matter.

General Pharmaceutical Benefits.

A letter was received from the Victorian Branch requesting that the Pharmaceutical Benefits Advisory Committee should be asked to draft and promulgate an authoritative statement for the guidance of medical practitioners and the Government on the advisable dosage and u[illegible] antibiotics. It was resolved that no action should b[illegible]n until the new work sheet, which was to be prepare[illegible] the Antibiotics Subcommittee of the National Health and Medical Research Council, was available.

A letter was received from the New South Wales Branch, which had communicated with the Director-General of Health after having received a complaint from one of its members. The member had wished to secure a larger quantity than was allowed of sulphonamide for four children who were receiving prophylactic treatment for rheumatic fever. The Deputy Director of Health for New South Wales had informed the member that according to the provisions of Regulation 27, the supplying of additional quantities of sulphonamide was not intended to be applied to cases involving prophylactic treatment only. The General Secretary said that he had sent the correspondence to the Director-General of Health, Canberra, asking if the ruling of the Deputy Director of Health for New South Wales was correct. He had received a reply from the Director-General, in which he stated that Regulation 27 of the *National Health Act* authorized that in special circumstances a greater number of repeats than were allowed by Regulation 20 applied in the case of chronic disease and in the treatment of persons suffering from malignant disease and other conditions which would warrant special consideration. The quantity of sulphonamide tablets that could ordinarily be prescribed had been determined on the advice of the Pharmaceutical Advisory Committee. It was not intended that greater supplies should be made available save under the circumstances to which the Director-General referred.

The General Secretary reported that requests had been received from the New South Wales Branch, from the Queensland Branch, from the Australian Pædiatric Association and from Dr. F. J. Spring, suggesting that certain substances should be included as additional benefits. The recommendations had been forwarded to the Director-General of Health.

A letter was received from the New South Wales Branch, protesting against the inadequacy of the drugs available for the "doctor's bag", and asking that further steps should be taken to have the list replaced by one more comprehensive. The General Secretary reported that he had sent the New South Wales letter to the several Branches. The Queensland, South Australian, Western Australian and Tasmanian Branches had agreed with the New South Wales suggestion, and the Victorian Branch had left the matter in the hands of its delegates. The request of the New South Wales Branch had then been sent to the Minister of Health, who had replied on May 20, 1954, that he regretted that the limited time available, owing to the fact that the regulations had to be gazetted no later than May 12, had made it impossible for him to discuss the matter further with the Council. He had, however, arranged for the deletion of the original proposal to include a certification in regard to stock on hand. In regard to the time factor, it was obvious that any limitation on the amount of a benefit supplied under the section would be quite ineffective, if a medical practitioner could write as many orders as he wished. In each State there were a number of doctors who continued to authorize an inordinate quantity of benefits, and it was felt that, given an opportunity of obtaining further supplies without the necessity for accounting for distribution, they would take advantage of such a privilege. Therefore, until some other effective means of controlling the supply of drugs under Section 93 was evolved, the present position would have to stand. Concerning the number of drugs to be made available, it was proposed to confine them at that stage to the ten drugs already submitted for the Federal Council's consideration. Any suggested additions or amendments to the list would then be considered in the light of experience. The Federal Council resolved that further consideration of the matter should be deferred until the next meeting.

A letter was received from the South Australian Branch, urging that the Federal Council should impress upon the Minister of Health the absolute necessity for doctors to obtain supplies of drugs for use by injection through wholesale houses. The South Australian Branch held that if doctors were allowed to deal directly with wholesale houses, a great saving in expense would be effected. The General Secretary said that the South Australian letter had been referred to the Branches. The Queensland and the New South Wales Branches did not agree with the South Australian suggestion. The Victorian Branch left the matter in the hands of its delegates, and the Western Australian and Tasmanian Branches agreed with the South Australian Branch. After discussion it was resolved that the Federal Council should impress upon the Minister of Health the advisability from the economic point of view of doctors obtaining supplies of drugs for use by injection through wholesale drug firms.

Reference was made to Section 99 (2) of the *National Health Act*, which stated that an approved pharmaceutical chemist or approved medical practitioner who had supplied a pharmaceutical benefit was entitled to payment from the Commonwealth in respect of the supply of that pharmaceutical benefit at the rate and subject to the conditions determined by the Minister in pursuance of the last preceding subsection and applicable at the time of supply. In the notes for approved chemists issued by the Department of Health, it was stated in regard to the dispensing fee that the fee applicable to the supply of benefits was eighteen pence. No dispensing fee was payable for the supply of (*a*) any insulin product, (*b*) doctors' bag supplies, and (*c*) benefits by an approved medical practitioner. The New South Wales, Queensland, Victorian and Tasmanian Branches had protested against the non-payment of a dispensing fee to an approved medical practitioner. It was stated in discussion that in certain country areas medical practitioners were compelled to do their own dispensing. It was therefore resolved that the Minister of Health should be asked to restore to an approved medical practitioner the dispensing fee for dispensing pharmaceutical benefits, thereby bringing the approved medical practitioner in line with the pharmaceutical chemist.

The General Secretary said that he had received from the New South Wales Branch a letter in which it was stated that it appeared to the Branch Council that the great majority of practitioners were completely unaware of the cost of drugs ordered by them. It was considered that it would be in the interests of all parties concerned if such information was made available to the practitioner. The Branch thought that the Federal Council should make a request for the Government to provide members of the profession with a schedule of approximate prices of drugs supplied under the National Health (Pharmaceutical Benefits) Regulations. The General Secretary said that he had sent the New South Wales letter to the Branches, and that the Branches had replied. The Queensland Branch did not approve of the suggestion of the New South Wales Branch. The Victorian Branch thought that practitioners should be informed of the prices of drugs supplied under the regulations. The South Australian Branch, the Western Australian Branch and the Tasmanian Branch agreed with the New South Wales Branch suggestion. In the discussion it was pointed out that the most expensive drug was not necessarily the best drug, as some persons seemed to think it should be. The Federal Council resolved that a request should be made to the Minister of Health to provide medical practitioners with a schedule of approximate prices of drugs supplied under the National Health (Pharmaceutical Benefits) Regulations.

A letter was received from the New South Wales Branch, drawing attention to the acute shortage of tetanus antitoxin for prophylactic purposes. Whereas doses of 10,000 international units were available, doses of 500, 1000 and 1500 international units, which were used for prophylactic purposes, were in very short supply, and it was understood that the position would not improve for some months. The General Secretary reported that he had sent the New South Wales letter on to the Branches. The Victorian Branch had replied that there had been a greatly increased demand for tetanus antitoxin in New South Wales and South Australia, following the threat by a coroner at an inquest on a child who had died of tetanus, and to whom antitoxin had not been administered, that in any such cases in the future he would commit the doctor concerned for trial for manslaughter. As a result reserve stocks had been depleted, but were now being built up again, and the position should be rectified within a few weeks. This information, the Victorian Branch stated, had been received from Dr. Morgan, Director of the Commonwealth Serum Laboratories. The Queensland Branch had replied that as far as was known there was no shortage of antitoxin in Queensland. The South Australian Branch said that there was no shortage in South Australia. In Western Australia the Director of Health had replied that he had completely run out of stocks of 500, 1000 and 1500 international units. There was no shortage of tetanus antitoxin in Tasmania. In view of the statement of Dr. Morgan that the position would be rectified in a few weeks, it was resolved that no action be taken.

Medical Benefits.

At the previous meeting of the Federal Council, reference was made to a letter which had been received from The Royal Australasian College of Physicians, dealing with an approach which had been made by the College to the Minister of Health in regard to provisions made for specialist consultant physicians, in the schedule of benefits, and the apparent anomalies which existed *vis-à-vis* the other branches of the profession. At that meeting regret was expressed that bodies other than the British Medical Association should approach the Government or other bodies in regard to matters affecting the profession. It was thought that there should be one negotiating body only to deal with such matters. It was resolved that an interview should be sought between executive officers of the College and of the Federal Council. The General Secretary reported that the President and himself had had a conference with Dr. C. G. McDonald, President of The Royal Australasian College of Physicians, and Dr. H. Maynard Rennie, the Honorary Secretary. The conversations had been most cordial, and while the College reserved the right to approach any governmental or other body in regard to matters affecting its members, it had agreed that the British Medical Association should be the one negotiating body for the whole profession.

Reference was made to suggested amendments in the schedule of benefits. The Ophthalmological Society of Australia (British Medical Association) had asked for advice in regard to the present position about the definition of professional attendance. It was stated that no benefit was allowed if the examination by an ophthalmologist included the estimation of a refraction. It was pointed out that many ophthalmological examinations could not be conducted without the estimation of a refraction, and it was thought that some provision should be made to rectify this anomaly. The Federal Council agreed to ask the Minister of Health to include certain words in the definition of professional attendance which would obviate the anomaly.

A request was received from the Tasmanian Branch, asking that an approach should be made to the Minister of Health with a view to allowing a benefit of 3s. to be paid for hæmoglobin estimation and microscopic examination of the urine when the patient had not been referred by another practitioner. In the discussion it was clear that the Tasmanian suggestion received no support from any of the

other Branches. Dr. D. C. Copping said that hæmoglobin estimation was surely part of the routine examination of a general practitioner or physician, and the same held in regard to the microscopic examination of urine. He said that if this sort of thing was permitted, before long requests would be made for a special benefit for the taking of a patient's blood pressure. It was resolved that no action should be taken.

A communication was received from the College of Radiologists of Australasia, suggesting amendments to the schedule of benefits for radiological service. The Federal Council resolved that the College of Radiologists should be advised that the Federal Council was acutely aware of the anomalies in respect of X-ray benefit, and that it was taking the matter up with the Minister of Health.

At the previous meeting of the Federal Council discussion took place on the definition of a specialist. The Federal Council had been asked by the Minister of Health to define a specialist in order that the payment of medical benefits under the Act might be facilitated. On that occasion the Federal Council accepted the following definition of a specialist: "That a specialist be defined as a registered medical practitioner who (*a*) possesses a degree or diploma of a recognized university, college or faculty which is a certificate of higher qualification in a special branch of medicine, or (*b*) while not possessing such a degree or diploma has been engaged for a period of not less than ten years in practice in a special branch of medicine, and further, who declares himself to be exclusively engaged in the practice of that specialty at a stated address. Nothing in this definition shall prevent a specialist from practising in other branches of medicine or as a general practitioner elsewhere." The General Secretary reported that he had sent the Federal Council's definition to the Branches and to the various specialist bodies in Australia. The replies were presented to the Federal Council, and it was clear that complete agreement had not been reached. The reply of The Royal Australasian College of Physicians included a statement that it was presumed that there would of necessity be a registered tribunal or statutory body to determine on behalf of the Minister those medical practitioners who should be regarded as specialists for the purpose of the *National Health Act*. The College was of the opinion that such a tribunal should be composed of representatives of the British Medical Association and the two Royal Australasian Colleges, the deans of the faculties of medicine in Australia, and one or two representatives of the other recognized special bodies outside the British Medical Association. The College was also of the opinion that the registering tribunal, when considering the registration of an applicant in a particular specialty, might in exceptional circumstances seek the advice of the appropriate professional body. The Royal Australasian College of Surgeons, in its reply, stated that it agreed with the submission of The Royal Australasian College of Physicians that any tribunal or other statutory body which might be set up to advise the Minister on the registrability of medical practitioners should provide for representation by the two Royal Australasian Colleges. It is impossible in the space available to reproduce the replies in full, but one or two points from them may be quoted. The Australian Orthopædic Association thought that a specialist must be exclusively engaged in the practice of the specialty and in no other form of practice. It could not agree that a man could be a true specialist at one address and a general practitioner, or a practitioner in any other specialty, at any other address. The Australasian Association of Psychiatrists wished to add a phrase in regard to the acceptance of a specialist as such by his colleagues in that specialty. The Australian Association of Neurologists added a provision that a practitioner should be considered as a specialist neurologist and defined as such when he had satisfied a body competent to judge that he himself was competent. The Australian Pædiatric Association sent a long reply, in which it was stated *inter alia* that it held the opinion that standards for certification were essential, and in order to meet the present deficiency it was willing to set up a board of certification. The College of Radiologists of Australasia expressed the opinion that the sentence "Nothing in this definition will prevent a specialist from practising in other branches of medicine or as a general practitioner elsewhere" should not apply to the definition of a specialist in radiology. The Dermatological Association of Australia thought that the Federal Council's definition was satisfactory. The Queensland Branch, in its reply, stated that the Federal Council should be concerned with the methods by which a register of specialists should be compiled, and should insist to the Department of Health that the body to be entrusted with this function should be exclusively medical in composition, with adequate representation of the Federal Council and the various associations of specialists. The reply of the New South Wales Branch had as its first clause a proviso that the specialist must be a registered medical practitioner who had served a period of at least one year as a resident medical officer in an approved hospital. The Ophthalmological Society of Australia (British Medical Association), in its definition of a specialist, stated the proviso that a specialist who did not possess a higher degree or diploma should *inter alia* be recognized as a specialist at the date of the promulgation of the regulation by the Federal Council of the British Medical Association in Australia, and be approved by the Minister of Health on the recommendation of the Federal Council. The Oto-laryngological Society of Australia added a proviso that specialist medical boards under the Federal Council of the British Medical Association in Australasia should be set up to deal with registrations. The Tasmanian Branch approved the Federal Council's definition *in toto*. The South Australian Branch's reply expressed the opinion that the most suitable bodies to define a specialist were the various specialist bodies themselves. At the same time it left the matter in the hands of its Federal delegates. In the discussion on these replies, it was clear that the members of the Federal Council held that the members of certain restricted specialties, such as pathologists and radiologists, could not be accepted as suitable persons to practise another "specialty at another address". The discussion centred around the definition of the New South Wales Branch. It was finally adopted in the following form:

> That a specialist be defined as a registered medical practitioner who:
>
> 1. shall have served a period of at least one year as a Resident Medical Officer in an approved hospital;
> 2. declares himself to be exclusively engaged in the practice of a particular branch of medicine or surgery at a stated address;
> 3. shall have had three years' practical experience in that specialty;
> 4. possesses a degree or diploma of a recognized University, College or Faculty which is a certificate of higher qualification in such special branch of medicine or surgery and which degree or diploma is registrable under the relevant State or Federal Act;
>
> or,
>
> 5. while not possessing such a degree or diploma has been engaged in practice prior to the date of the institution of registration of specialists in a special branch of medicine or surgery for a period accepted as adequate by an appropriately constituted Board of Reference.
>
> Nothing in this definition will prevent a specialist from practising in other branches of medicine or surgery elsewhere.

The Federal Council also resolved that the Federal Government should be invited to accept the definition of a specialist as put forward by it, and as a corollary to allow it in association with specialist bodies to set up Federal or State boards of reference and to compile a register of specialists. The Federal Council resolved to ask the Branch Councils to constitute committees for the purpose of compiling a register of specialists. The Federal Council also resolved to set up a Federal board of reference consisting of three members of the Federal Council and one representative each of the Royal Australasian College of Surgeons and The Royal Australasian College of Physicians. The three representatives chosen to act on such a board were Dr. A. J. Collins, Dr. A. J. Murray and Dr. H. R. R. Grieve.

The Federal Council discussed the question of the provision of benefits for persons with chronic and preexisting illnesses. It had before it a letter which had been sent from the New South Wales Branch in July, 1954. The letter stated that members in New South Wales were greatly concerned at the fact that many of their patients were expressing disapproval of the present medical benefits scheme, because they were able to obtain only the Government benefits for chronic and preexisting diseases. In other words, they were not able to obtain benefits from the medical benefit organizations. These members had made representations to the Branch Council on the matter. It was fully realized by the Council that to admit a person with a preexisting disease and to pay benefits for such a condition immediately after the person joined the fund would call for a complete revision of the contribution rate. The Medical Benefits Fund of Australia had recently seen fit to amend its rules to pay benefits for preexisting diseases after the contributor had completed two years of membership. It also paid for all chronic disease that might develop after

the contributor joined the fund other than pulmonary tuberculosis and certified mental diseases. It did not pay benefits in cases of alcoholism and drug addiction. Time only would tell whether the waiting period for preexisting diseases could be reduced from two years without any undue risk being placed on the fund. Towards the end of 1953 a meeting of delegates of the Local Associations in New South Wales had expressed the opinion that medical benefit funds should pay benefits in cases in which contributors were treated for preexisting and chronic disease, and in the event of any financial loss resulting from such a procedure, the medical benefit organization should be reimbursed by the Government. It was suggested that the help of the Minister of Health should be obtained in this regard. The Council of the New South Wales Branch realized that such a proposal might well lead to members of the public not joining funds until medical attention was necessary. Nevertheless it was felt that the possibility of obtaining some extension of cover for chronic and preexisting diseases should be explored, and to this end the Branch Council recommended that an approach be made to the Government. The General Secretary said that this letter had been sent to the Branches, and that replies had been received. The Queensland Branch did not agree with the recommendation of the New South Wales Branch. The Victorian Branch supported the proposal of the New South Wales Branch. The South Australian Branch wrote that it was in agreement with the principle that people now excluded from receiving benefits from voluntary organizations by reason of chronic and preexisting illnesses should be eligible to receive free benefits in exactly the same way as other members of the community. The Western Australian Branch agreed to the proposals of the New South Wales Branch, and the Tasmanian Branch also agreed. After discussion it was resolved that the Minister of Health should be requested to give consideration to the subsidizing of medical benefit organizations, in order that fund benefits might be paid to persons suffering from preexisting illnesses during the period of their exclusion from benefits.

The Federal Council discussed the furnishing of information by medical practitioners in connexion with the illness of patients. It had before it a letter from the New South Wales Branch, in which it was stated that it would appear to be common for requests to be made for diagnoses to be supplied by either the medical attendant or the patient before the payment of a medical benefit was made. It was true that in most cases the request made of the medical attendant was on authority of the patient, but nevertheless the supplying of the information might cause embarrassment to the patient. Whilst it was to be admitted that the Medical Benefits Fund might require a diagnosis at times to ensure that it would not be liable for benefits for a preexisting disease, there was otherwise generally no need for a diagnosis. All that a doctor was required to state was the nature of the service. The Branch Council recommended to the Federal Council that it give consideration to the finding of a formula which would obviate the necessity for the supplying of a diagnosis to a medical benefit organization by either the doctor or the patient before the patient could receive his medical benefit. The General Secretary reported that this letter had been referred to the Branches, and the replies had been received. The Queensland Branch riterated its previous opinion that information should be given to the patient to pass on to the benefit fund. The Victorian Branch supported the views of the New South Wales Branch. The South Australian Branch left the matter in the hands of its delegates. The Western Australian Branch agreed with the suggestion of the New South Wales Branch. It also stated that although any procedure performed must be indicated on the account to enable the society to determine the rebate available to the contributor, an arrangement had been come to with benefit organizations in Western Australia that it was no longer necessary to insert the diagnosis in the case of a brief illness occurring within one month. The Tasmanian Branch agreed with the views of the New South Wales Branch. In discussion it was agreed that the existence of the clause in regard to preexisting illnesses was a bar to the withholding of information. The Federal Council resolved that while a disability exclusion clause existed, it was inevitable that the patient must furnish the medical benefit organization on request with a diagnosis, in order to determine whether the service was for a preexisting disability.

The General Secretary stated that a letter had been received from the Tasmanian Branch, in which it was suggested that some payment should be made to cover the cost of mileage in connexion with visits to patients in country areas. The matter had been referred to the Branches, and the Federal Council, after discussion, resolved that no further action should be taken.

Reference was made to the Commonwealth Department of Health document, "M.B. Circular No. 9", and particular attention was drawn to clauses 12 to 16 inclusive. These clauses dealt with Commonwealth benefit where medical expenses were payable to a hospital. The clauses stated that under Section 19 of the *National Health Act* the Commonwealth benefit was not payable in respect of a professional service where the medical expenses in respect of that service were paid or payable to an authority conducting a public hospital, or to a person or body of persons acting on behalf of an authority conducting a public hospital. This provision was not to apply where the Minister of Health was satisfied that a professional service rendered at a public hospital at a particular place was not otherwise available at that place. In defining the term "public hospital", the clauses went on to state that in view of the arrangement at present existing in Australia for the provision of medical benefits, the Minister had authorized under Section 19 (2) payment for Commonwealth benefit in respect of each of the following services when rendered at any public hospital, for which fees were charged by the public hospital authority: Schedule Items 201 to 228, pathological services; Schedule Items 301-318, radiological services; Schedule Item 332, electrocardiogram. As a general rule it might be assumed that these services had been performed on behalf of a medical practitioner. They would therefore be "professional services" as defined in Section 13 (1) of the Act, and as such would rank for Commonwealth benefit. Unless there was reason to believe that these services were performed at hospitals otherwise than on behalf of a medical practitioner, itemized hospital accounts covering the services might be accepted as evidence that the services were professional services as defined, notwithstanding that the names of the medical practitioners rendering or requesting the services were not shown. Should there be any doubt that such a service had been rendered by or on behalf of a medical practitioner, the name of the medical practitioner should be sought. The last of these clauses stated that the operation of Part 3 of the *National Health Act* would affect the Commonwealth benefit currently payable in respect of other professional services which were rendered at public hospitals, and for which fees were charged by the hospital authority. Up to that time, under the National Health (Medical Benefits) Regulations, Commonwealth benefit had been payable for all these medical services, provided they were professional services as defined and medical expenses had been incurred. This would continue to be the position in regard to services rendered between July 1, 1953, and the date of the repeal of the regulations, but no Commonwealth benefit would be payable in respect of these services when dated on or after the effective date of operation of Part 3 of the Act. The Federal Council resolved to inform the Minister of Health that the Council regarded the exercise of his discretion in a number of cases in districts where private pathological and radiological services were available, as destructive of the principle of the Act that benefit should be paid for private medical services.

The Federal Council also had before it Commonwealth Health Department "M.B. Circular No. 11", which consisted of notes for the guidance of registered organizations.

At the instance of the New South Wales Branch, the Federal Council discussed the method of payment under the medical benefits scheme. The New South Wales Branch had written stating that the Warringah District Medical Association had asked that in those cases in which the contributor had not paid the doctor's account, but had requested a medical benefit fund to pay the amount of the benefit direct to the doctor, the fund should make the cheque payable to the doctor and not to the contributor. It was to be noted in this regard that the Medical Benefit Fund of Australia made the cheque payable to the doctor and endorsed it "Not Negotiable", "Account payee only". The Central Western Medical Association had advised that some patients were paying small accounts by presenting to the doctor a cheque from the Medical Benefits Fund and refusing to pay the balance of the account. In view of the importance of the matter, the Branch Council recommended to the Federal Council that the matter of the payment of medical benefits by registered organizations be taken up with the Minister of Health. The General Secretary said that the letter had been sent to the Branches. He also drew the Federal Council's attention to a statement which had appeared in "News Bulletin Number 133" of the Queensland Branch for July 1, 1954. The statement was as follows: "Another item which offends some doctors is the receipt of cheques covering part payment of accounts, sent direct from approved organizations. Your Council does not approve of this, but you must remember that the National Health Act makes payment in this way compulsory when the insured person presents an unpaid account with his claim and

requests that the benefit be forwarded to the person who rendered it. Perhaps after all it is better to receive a portion rather than nothing." The Queensland Branch Council had replied that it was not aware of a benefit having been paid to a contributor where the contributor had not paid the doctor's account; if, however, this had occurred, the Council fully supported the request of the New South Wales Branch. The Victorian Branch informed the Federal Council that the policy of the Branch Council was that medical benefits should be paid as refunds to patients on presentation of the receipted accounts to benefit organizations, and the Council was unwilling to facilitate any departure from this policy. The South Australian Branch wrote that the New South Wales Branch letter had been received without comment. The Western Australian Branch in its reply had set out a complicated procedure, by means of which, when the patient made a plea of hardship, the payment could be made directly to the attendant practitioner. It stated that the cumbersome procedure was made so on purpose, in order to deter abuses. The need for such a procedure in Western Australia had been "practically minimal". The Federal Council resolved that no action should be taken for the present.

The Federal Council discussed the payment of medical benefits to patients occupying beds in public hospitals. It had received a letter from the New South Wales Branch, in which it was stated that there was a general demand from members of the profession in New South Wales that payment for medical services should be made by persons who were admitted to public beds in public hospitals, but who were members of medical benefit funds. In this regard the Council had recently amended its hospital policy to provide for a new class of patient—namely, "insurance" patients—to be added to the present classification of private, intermediate and public patients, if they were admitted to public beds in a public hospital. Recently a deputation from the Council had waited on the State Minister of Health to discuss the matter with him. The Minister had indicated that he was sympathetic to the view that a doctor should be entitled to make a charge, but he thought that the doctor should waive his claim to any amount over and above the benefit payable to the contributor. In view of the importance of the matter, the New South Wales Branch submitted the matter to the Federal Council, that it might be discussed on a Federal basis. The General Secretary stated that the Victorian and Queensland Branches did not agree with the New South Wales view. The Tasmanian Branch agreed, and the South Australian Branch approved of the ideas set out in the New South Wales Branch letter, but advised of the difficulties which had arisen in South Australia. It was stated that the Minister of Health in New South Wales had convened a conference to discuss the matter. Dr. W. F. Simmons suggested that if the idea was adopted, the Medical Benefits Fund would be ruined. Dr. H. R. R. Grieve reminded the Federal Council of its policy that the patient should pay a fraction of the fee. He sympathized with the views of doctors who were being cheated. If the patient paid nothing, there would be no control over the number of services which were given. After further discussion the Federal Council resolved that it did not approve the payment of medical benefits under the *National Health Act* to insured persons in public beds of public hospitals on this ground among others, that such policy conflicted with the Federal Council's policy that the patient should pay the whole or a fraction of the fee for treatment.

Medical Service Committees of Inquiry.

The Federal Council considered a communication from the Western Australian Branch dealing with the way in which Committees of Inquiry were conducted. Dr. C. W. Anderson, in explaining the matter, said that exception was taken to the presence of Hansard reporters, who took a complete account of the evidence. The presence of these reporters destroyed the atmosphere in which the inquiry should be conducted. The inquiry ceased to be a conversation between doctors, and assumed a formal aspect. Dr. L. N. Gollan said that at inquiries which he had attended in Tasmania, Hansard reporters had been present. Dr. H. R. R. Grieve said that the presence of reporters was necessary. Dr. H. W. Horn said that inquiries were only inquiries and nothing more, and it would be a pity to destroy any friendly atmosphere which might exist. Dr. H. C. Colville agreed with Dr. Anderson. He objected to lay people being present. He thought that if a transcript had to be kept, it might be possible to obtain the services of someone connected with the Branch of the State in question. The General Secretary said that the reporting of evidence was a highly technical job. An ordinary stenographer could not do it. If an accurate and detailed account was necessary, it was essential to employ a Hansard reporter. Further consideration of the matter was deferred.

Reference was made to the Medical Services (Federal) Committee of Inquiry. This consisted of Dr. A. J. Collins, Dr. W. F. Simmons, Dr. H. R. R. Grieve and Dr. J. G. Hunter.

Reprimand of Medical Practitioners.

Reference was made to the reprimand which had been given to three medical practitioners—one in Queensland and two in New South Wales. The view was expressed that, although the fact of a reprimand having been given was gazetted and published, that fact did not act as a deterrent, because no information was given as to why the reprimand had been made. No recommendation in regard to this matter was made.

Pharmaceutical Benefits Advisory Committee.

The Federal Council noted the appointment of the following as members of the Pharmaceutical Benefits Advisory Committee: Dr. A. J. Collins, Dr. L. R. Mallen, Dr. Byron Stanton and Dr. Robert Southby, together with Professor R. H. Thorp (pharmacologist), Mr. R. E. Thomas (Federated Pharmaceutical Service Guild) and Mr. G. G. Jewkes (Department of Health). The President referred to the services which Dr. F. W. Carter and Dr. A. W. Morrow had given to the Pharmaceutical Benefits Advisory Committee, and the Federal Council recorded its thanks to them for their work.

Campaign Against Tuberculosis.

A letter was received from the New South Wales Branch, asking for the comments of the Federal Council. In this letter it was explained that a medical practitioner who practised as a radiologist at Katoomba, New South Wales, had had his appointment as honorary radiologist to the local hospital terminated by the hospital board. He had stated that the reason was that he had declined to act as radiologist to the chest clinic of the hospital, as no patient attending it was subjected to a means test, and no fees were charged. The board of the hospital was prepared to pay the radiologist for attendance at the chest clinic on a sessional basis, and apparently was only acting in accordance with an agreement between the Commonwealth Government and the State Governments, that there should be no charge for the treatment of patients suffering from tuberculosis. The New South Wales Branch Council was of the opinion, however, that whilst no means test should apply to radiological surveys up to the point of diagnosis, it should apply subsequently. The New South Wales Branch Council recommended to the Federal Council that it should take the matter up with the Commonwealth Government, and that the means test should be applied in chest clinics on the basis referred to in the New South Wales Branch letters. After discussion the Federal Council resolved to take the matter up with the Commonwealth Government, and to express the opinion that whilst no means test should apply in any radiological survey up to the point of diagnosis, a means test should apply once a diagnosis had been made.

Administration of Health Services.

At the previous meeting of the Federal Council, consideration was given to a report which had been presented on the administration of a health service. This had been prepared by Dr. C. E. Cook, when he was Commissioner of Public Health in Western Australia. The Federal Council deferred consideration of the document on that occasion, because the Queensland Branch was the only Branch that had considered it. At the previous meeting Dr. D. E. Copping and Dr. C. W. Anderson both reported that the scheme suggested by Dr. Cook had been working in Western Australia for some years and with considerable success. The matter was again considered, and the view was expressed that Dr. Cook's document was very valuable, but that because of the diversity in the conditions existing in the different States, the Federal Council did not think that it should take any action in the matter.

Hospital Policy.

Reference was made to a document received from the College of Radiologists of Australasia in regard to the appointment of radiologists to public hospitals. The document dealt first of all with appointments in general, and then with the appointment to Canberra Hospital in particular. It was explained that the authorities of the Canberra Hospital wished to employ a radiologist and collect the fees for all the work which was done. This was a method of boosting the finances of the hospital. The General Secretary gave some details of the difficulties associated with the Canberra appointment, and the Federal Council decided to leave the matter in his hands.

Publicity Committee.

The Publicity Committee of the Federal Council was reappointed as follows: Dr. A. J. Collins, Dr. W. F. Simmons, Dr. H. R. R. Grieve, Dr. A. E. Lee, Dr. L. R. Mallen and Dr. C. H. Dickson.

Australasian Post-Graduate Federation in Medicine.

The General Secretary explained that he had received a notice of the general meeting of the Australasian Post-Graduate Federation in Medicine, to be held in Melbourne on May 25, 1954, and had asked Dr. H. C. Colville to act as representative of the Federal Council. Dr. Colville had consented to do this, but unfortunately at the last moment he had been prevented from attending.

The Federal Council Medical Monograph Fund.

Dr. W. F. Simmons, the Honorary Treasurer, made a statement in regard to the condition of the Federal Council Medical Monograph Fund. At the time of the meeting the total subscribed was £2179 4s. 2d., and he recommended that £2000 of the money standing to the credit of the fund should be invested in Commonwealth bonds. This would leave a small amount in the current fund for immediate use should occasion arise.

The General Secretary laid before the Federal Council a draft of the trust deed of the fund. This had been drawn up by the legal advisers of the Federal Council, and was necessary for several reasons. One of these was that an attempt would be made to obtain consent from the taxation commissioner for donations to the fund to be made allowable deductions in income tax returns.

British Medical Association.

The General Secretary said that he had received from the Public Relations Department of the Parent Body a list of medical conferences which were to be held during 1954 in different parts of the world. Copies of this list had been forwarded to the Branches.

The General Secretary also reported that he had received from the London office a copy of a memorandum entitled "The Rehabilitation and Resettlement of Disabled Persons". Copies of this document would be available to those who were interested in the subject.

In reference to the annual meeting of the Association held at Glasgow from July 1 to 9, 1954, the General Secretary said that the Federal Council could not nominate a representative to attend on its behalf. He had, however, asked the London office that some prominence should be given to Sir Samuel Burston, and he has been asked to speak at one of the functions.

British Commonwealth Medical Conference.

The General Secretary reported that the next British Commonwealth Medical Conference was to be held at Toronto in June, 1955, and he suggested that the Federal Council should appoint an Australian delegate. The conference would take place at about the same time as the annual meeting of the Parent Body, which was to be held in 1955 in Toronto. On the nomination of Dr. L. R. Mallen, seconded by Dr. Angus Murray, Dr. H. R. R. Grieve was appointed representative to the conference at Toronto. In supporting this nomination, several speakers expressed the hope that Dr. Grieve would be able to visit the United States as well as Canada, in order to learn at first hand the latest information about schemes of voluntary insurance and allied matters. Dr. Grieve thanked the members for his nomination.

World Medical Association.

The General Secretary reported that he had received from the General Secretary of the World Medical Association reports of the twentieth meeting of the council, held at Zurich, Switzerland, from April 22 to May 1, 1954. He also said that he had received from Dr. L. R. Mallen a report of the meeting of the council of the World Medical Association.

The General Secretary reported that Dr. H. W. Horn had accepted the Federal Council's invitation to act as a delegate to the eighth general assembly of the World Medical Association, to be held at Rome from September 26 to October 2, 1954. He also suggested that as Dr. Mervyn Archdall, Editor of THE MEDICAL JOURNAL OF AUSTRALIA, was going to Rome to attend the meeting on medical journalism, he should be appointed alternative delegate to the general assembly. The General Secretary's suggestion was accepted.

The General Secretary said that he had received from the General Secretary of the World Medical Association a letter inquiring whether the Federal Council desired any items to be placed on the agenda for the eighth general assembly. He also said that he had received from Dr. C. J. King, a member of the New South Wales Branch, a letter asking that he might be appointed an observer in connexion with the general assembly. It was explained that as many observers as was desired might be appointed.

The General Secretary said that he had received from the General Secretary of the World Medical Association an invitation to the Federal Council to send a representative to the fifth medical journalism meeting. The Editor of THE MEDICAL JOURNAL OF AUSTRALIA had also received an invitation. The directors of the Australasian Medical Publishing Company, Limited, had agreed to send the Editor to attend the meeting.

The General Secretary reported that he had received from the World Medical Association a chapter formulated by the Committee on Medical Ethics for inclusion in the Code of Medical Ethics of the World Medical Association, and asking for the comments and recommendations in regard thereto. The document had been forwarded to the Branches. The Federal Council formally approved of the document.

The General Secretary said that he had received from the editor and business manager of the *World Medical Journal* a request for information in regard to the registration of specialists in Australia. He had replied that the registration of specialists in Australia was carried out in Queensland only.

A document dealing with the International Labour Organization entitled "The I.L.O.—What It Is" had been received. This document had been published in *The I.L.O. News Sheet*. The document was noted.

The General Secretary of the World Medical Association had forwarded fifteen conclusions concerning the relations between social security institutions and the medical profession, adopted at the eleventh general meeting of the International Social Security Association at Paris on September 7 to 11, 1953. On the motion of Dr. L. R. Mallen it was decided that consideration of this document should be deferred until after the general assembly had met at Rome.

A communication had been received from the World Medical Association in regard to the World Health Organization campaign to abolish the importation and production of heroin. The World Medical Association asked member associations to seek the cooperation of their member doctors in eliminating the use of heroin by professional agreement rather than by legislative measures. The General Secretary said that he had informed the Secretary-General of the World Medical Association that the importation of heroin into Australia had been prohibited after consultation with the members of the medical profession.

A *questionnaire* had been received from the World Medical Association in regard to cooperation in international occupational health services. The *questionnaire* had been forwarded to the Branches, and their replies would be incorporated in the document which would be returned to the World Medical Association.

Further reference was made to the production of an international pharmacopœia. The General Secretary said that he was still awaiting a reply from Dr. Byron Stanton, who had so far been unable to supply the necessary information.

A request had been received from the Secretary-General of the World Medical Association, inquiring if the Federal Council would appoint one or more correspondents, who would submit material regularly to the *World Medical Journal*. The General Secretary had discussed the matter with the President of the Federal Council, and had forwarded the names of himself and of the Editor of THE MEDICAL JOURNAL OF AUSTRALIA as correspondents.

A letter had been received, advising the General Secretary of the visit to Sydney of Dr. Irene A. Koeneke and Dr. Francis Schultz, and of their willingness to give post-graduate lectures. The letter had been sent on to the Post-Graduate Committee in Medicine in the University of Sydney.

Further reference was made to the appointment of Supporting Committees, whose object it would be to collect funds for the promotion of the activities of the World Medical Association. The South Australian Branch had forwarded to the General Secretary a cheque for £220 19s. 6d. It was explained that this money had been collected by requests for an addition to the usual Branch subscription. Dr. H. C. Colville said that a Supporting Committee had been appointed in Victoria, but that so far it had not become active. Dr. L. R. Mallen said that he hoped the other States would follow the example of South Australia.

Reference was made to the representation of the Federal Council at the assembly of the World Medical Association, to be held in 1955 at Vienna. The appointment of a delegate to this assembly was deferred. Dr. Mallen pointed out that the World Medical Association did not wish to have as delegates persons who were unfamiliar with the activities of the British Medical Association in Australia. Casual visitors were useless.

National Health and Medical Research Council.

The General Secretary reported that prior to the thirty-seventh session of the National Health and Medical Research Council, which was held at Sydney on May 19 and 20, 1954, he had received from Dr. W. F. Simmons his usual inquiry whether the Federal Council or the Branches desired any items to be placed on the agenda of the session. He also said that Dr. Simmons had forwarded his report of the session. The Federal Council thanked Dr. Simmons for his valuable report, and expressed its appreciation of the work which he had done on behalf of the Council over a period of years.

The General Secretary stated that at the thirty-sixth session of the National Health and Medical Research Council, held at Canberra on December 4, 1953, a request had been made to the Commonwealth Government for an increased grant for research. At its meeting in March, 1954, the Federal Council had resolved that the strongest possible support should be given by the Federal Council to the request of the National Health and Medical Research Council for an increased grant for medical research. The General Secretary reported that he had sent this resolution to the Minister of Health, who had replied that he would place the letter before the Commonwealth Treasurer.

Further reference was made to the proposal that social service benefits should be made available to sufferers from Hansen's disease, in the same way as they were made to sufferers from tuberculosis. The Minister of Health had replied that the matter had not been brought to finality, and that there was no likelihood of this being done in the immediate future. In the discussion it was pointed out that the introduction of a special Act for this purpose would be required.

The General Secretary said that Dr. W. F. Simmons had forwarded documents received from the chairman of the National Health and Medical Research Council, which had been prepared by the Department of Scientific and Industrial Research of Great Britain. These documents dealt with the use of crash helmets for motor cyclists.

The Federal Council appointed Dr. W. F. Simmons to act as its representative for a further period of three years commencing January 1, 1955.

A letter was received from the New South Wales Branch, asking that the Commonwealth Government should be requested to replace the National Health and Medical Research Council with a National Medical Research Council and a National Health Council. The letter had been forwarded to the Branches. The Victorian Branch had replied that in its opinion additional information was needed before such a request should be made. The General Secretary traced the history of the National Health and Medical Research Council, which had been established by Sir Earle Page and Dr. J. H. L. Cumpston. Dr. W. F. Simmons explained that the establishment of a science committee of the National Health and Medical Research Council had overcome most of the difficulties existing prior to the establishment of this committee. He set out the names of the members of the committee, and pointed out that the members were to all intents and purposes the same as those who would be chosen by the Federal Council if it had to appoint a medical research council. The New South Wales Branch letter was received.

Repatriation Department.

Medical Benefits for Widows, Widowed Mothers and Orphans of the 1914-1918 and 1939-1945 Wars.

The General Secretary reported that he had received from the Chairman of the Repatriation Commission a letter dealing with the request of the Federal Council that the capitation basis of payment for attendance on widows, widowed mothers and orphans of the two World Wars should be amended to a fee-for-service basis. The Chairman stated that the Commission had considered the proposal, but before a final decision was reached it asked for information as to the scale of fees that the Federal Council had in mind. The General Secretary said that he had forwarded this letter to the Branches, and that replies had been received. In conformity with these replies, the Federal Council resolved that the Repatriation Department should be informed that the Federal Council was of the opinion that the payment for services rendered to widows, widowed mothers and orphans of the 1914-1918 and 1939-1945 wars should be at least the same as that paid to local medical officers for attendance on ex-service personnel.

Fees Payable to Local Medical Officers.

Reference was made to the fees payable to local medical officers of the Repatriation Department. The General Secretary read a letter which had been received from the Chairman of the Repatriation Commission in April, 1954. In this letter the Chairman referred to the Federal Council's letter of December, 1953, in which a request had been made for an increase of the fee payable to Repatriation Commission local medical officers for attendance on ex-service personnel on public holidays and week-ends from 12s. 6d., the normal fee, to £1 1s. The Chairman of the Repatriation Commission went on to state that in conjunction with the Department of the Treasury the Commission had given careful consideration to the request, but was unable to agree to the increased fee for attendance on public holidays and week-ends. It was considered that the present fee of 12s. 6d. per visit, irrespective of the time involved in each visit, was reasonable. The Chairman went on to suggest that, as the fees to be paid by the Commonwealth departments to medical and other professional persons required the approval of the Treasurer, any future requests by the Federal Council for an increase in fees payable by the Repatriation Department should also be made to the Treasurer.

The General Secretary read a letter from the New South Wales Branch which had been sent to the Branches. In this letter it was stated that the New South Wales Branch had recommended to the Federal Council that the fees for attendance on widows, widowed mothers and orphans of the two World Wars should be 15s. for a surgery consultation and 17s. for a visit. It also recalled that the Federal Council had requested the Department of the Army to make these fees payable to area medical officers. The New South Wales Branch Council thought that it would be much more satisfactory if a uniform schedule was introduced to cover services rendered on behalf of all government departments on a fee-for-service basis. Accordingly the Branch Council recommended to the Federal Council that it make representation to the authorities that the fees payable to local medical officers for attendance on ex-servicemen on behalf of the Repatriation Department should be increased to 15s. for a consultation and 17s. 6d. for a visit. The General Secretary said that the New South Wales Branch letter had been sent to the Branches. He read the replies of the Branches. The Queensland Branch pointed out that in Queensland the general practitioner fees were 15s. per consultation and £1 1s. per visit. The Victorian Branch left the matter in the hands of its delegates. The South Australian, Western Australian and Tasmanian Branches supported the New South Wales Branch view. The Federal Council resolved that the Chairman of the Repatriation Commission should be informed that the Federal Council did not propose to accede to his suggestion that requests for increased fees and similar matters should also be made to the Treasurer. It was also resolved that representations should be made to the Repatriation Department that fees payable to local medical officers should be increased to 15s. for a consultation and 17s. 6d. for a visit. It was also resolved that a further approach to the Repatriation Department in regard to an increase in fees for emergency treatment at week-ends and holidays should be made.

Fee for Consultation at a Specialist's Rooms.

At the previous meeting of the Federal Council, reference was made to the fee paid for consultation at a specialist's rooms. On that occasion it was reported that the Federal Treasurer had offered a fee of £2 10s. for a consultation with a specialist in his rooms to patients referred by Government departments. The Treasurer had, however, been informed that the payment was inadequate. The General Secretary reported that no increase had been obtained, and the Federal Council resolved to reiterate to the Department of the Treasury that the correct fee for consultation in a specialist's rooms was £3 3s., and that in addition the Federal Council should inform the Treasurer that the reasons for such a proposed reduction as he had offered were not well known to the medical profession, and that the Federal Council should be informed why the reduction had been made.

Fees Payable to Visiting Medical Officers.

The General Secretary reported that just prior to the elections an advertisement authorized by the Repatriation Department appeared in the lay Press calling for applications for all positions on the visiting staffs of Repatriation Depart-

ment hospitals. Because of complaints received from members of visiting staffs that terms and conditions of appointment had been varied without reference to the staffs, he made inquiries and ascertained that the remuneration offered had been a reduction on the amount previously paid, which amount, in the opinion of the Federal Council, had been inadequate. The President of the Federal Council had communicated with the Minister for Repatriation, who said he had been unaware of the advertisement in question, and had agreed to suspend action until after the elections had taken place. However, the President had subsequently received a telegram stating that the Minister was unable to agree to further extension. The telegram went on to state that agreement had been reached at a conference between both Health and Repatriation Departments and the Treasury. The Minister for Repatriation understood that health specialists had been working for some time at the proposed repatriation rates, which had been designed to place specialists engaged by both departments on the same footing. Any over-all increase in specialists' fees for both departments could be discussed should the occasion arise. The President had later on written to the Minister for Repatriation, and had referred to the Minister's inability to agree to the representations that the President had made to him. The President noted, however, that the Minister had indicated his willingness to discuss the rates of payment of visiting medical officers should the necessity arise. The President assured the Minister that there was much dissatisfaction amongst members of the medical profession regarding rates of payment for specialist services in Commonwealth departments, and added that the Federal Council proposed to make strong representations to the Treasury in the matter at an early date. In view of this fact, medical practitioners engaged in specialist practice had agreed to submit applications for the positions of visiting medical staffs at repatriation hospitals. The Federal Council resolved that an interview should be sought with the Minister for Repatriation, and it decided that the arrangements for such a conference should be left in the hands of the President and the General Secretary.

Fees Payable to Medical Practitioners Acting on Assessment Appeal Tribunals.

At a previous meeting the Federal Council discussed the fees payable to medical members of Assessment Appeal Tribunals. It held that the fee of five guineas was quite inadequate. It resolved to make a request that the fee should be increased to ten guineas. A reply had been received from the Minister for Repatriation, stating that it was not possible to agree to the request of the Federal Council that the suggested increase should be made. The Minister pointed out that a session of the Assessment Appeal Tribunal was regarded as a minimum period of three hours, provided that a medical member attending a session of two and a half hours or more should receive the full fee for that session. The fees were five guineas for one session and ten guineas for two full sessions on the one day. This was subject to the proviso that irrespective of the time occupied by any particular session, if more than five cases were considered at a session, a fee of six guineas should be paid in respect of six cases, and seven guineas for seven or more cases. The Minister thought these fees compared favourably with those payable to visiting specialists.

The General Secretary referred to the replies that had been received from the Branches when this matter had been referred to them. The Council of the Queensland Branch expressed the opinion that the work of the tribunals was quite different from that of visiting specialists. It involved such responsibility that the employment of leading members of the profession was most desirable, and the present fees were inadequate to attract these men. After discussion the Federal Council resolved to take no further action for the time being.

Fees for Radiological Examination.

At a previous meeting of the Federal Council consideration had been given to a communication from the College of Radiologists of Australasia, which had not been satisfied with the fees offered for the taking of a bronchogram and a report on it. The Department had been communicated with, and a lower fee than that requested had been offered. The Federal Council thought that in the circumstances it should take no further action.

Form 70: Prescription Form.

Reference was made to the prescription form issued by the Department of Repatriation. A letter was received from the New South Wales Branch, drawing attention to several defects in this form. It was thought that clarification was needed of the words on the form: "No prescription must exceed one month's supply." It was pointed out that these words might be interpreted as meaning that a "repeat" prescription came within the one month's supply, although it was understood to be otherwise. There was an objection by local medical officers in having to sign the prescription twice if a repeat was advised. It was resolved that the criticism of the New South Wales Branch be forwarded to the Repatriation Department, with the request that the objectionable features of Form 70 be removed, and that the words "no prescription must exceed one month's supply" should be clarified. The Federal Council also resolved to ask that in future it should be consulted in regard to any alteration to Form 70.

Salaried Medical Officers.

The General Secretary reported that he had appeared before the Public Service Arbitrator at Sydney in regard to the conditions of service of medical officers of the Department of Repatriation. He had not yet heard the result of the inquiry, but he thought that probably some increases would be obtained.

Rehabilitation Branch of the Department of Social Services.

The General Secretary reported that he had received a letter from the Director-General of Social Services, advising of an increase in the fee for completion of Form R6 from one guinea to £1 5s. if the examination was made at the doctor's surgery, and from £1 5s. to £1 11s. 6d. if the examination was made at the patient's home.

A letter was received from the Queensland Branch, protesting against the reduction in fees for rehabilitation panels, and suggesting that a protest be made to the Minister for Social Services and to the Treasury. The New South Wales Branch had written in this regard suggesting that steps should be taken to have a uniform schedule of fees operating in respect of all government departments. The Federal Council resolved to send the Queensland Branch's protest to the Minister for Social Services.

Income Tax and Social Services Contribution Assessment Acts.

From a previous meeting of the Federal Council, a request had been made for an increase in the fee payable to Commonwealth medical referees for examination of an "invalid relative". The fees payable at the time when the request was made were 10s. if the patient was examined at the consulting room and 15s. if he was examined at his own home. The General Secretary now reported that the Acting Treasurer had advised that the fee had been increased to one guinea if the examination was conducted at the surgery and £1 5s. if the examination was made at the patient's home. The increase was noted.

Reference was made to the depreciation allowance on X-ray apparatus. This had been considered at the request of the College of Radiologists of Australasia. At the previous meeting of the Federal Council consideration had been deferred until information had been supplied by the College of Radiologists, setting out detailed reasons for the making of the request. The General Secretary said that some reasons had now been advanced, and the Federal Council resolved that the matter should be left in the hands of the General Secretary.

Department of the Army.

At its previous meeting the Federal Council discussed the making of a request to the Department of the Army that fees payable to area medical officers should be increased as follows: for a visit to a patient's home from 15s. to 17s. 6d.; for attendance at a practitioner's surgery from 10s. 6d. to 15s. The General Secretary explained that it had been thought that it would be wise to leave this matter over until the whole of the subject had been discussed. The Federal Council also had before it a copy of a letter received by the Queensland Branch from the Deputy Director of Medical Services of the Northern Command, setting out the fees payable to medical practitioners for various types of service. The Queensland Branch thought that the Federal Council should take up the matter of fees payable to civil practitioners with the Department of the Army. The Federal Council had before it a scale of fees suggested by the New South Wales Branch. This scale was approved.

Medical Inspection of Seamen.

Reference was made to the fees payable for medical inspection of seamen, and the Federal Council resolved to make a request to the Minister for Shipping that the fees payable to

a medical inspector of seamen who was not a member of the Commonwealth Public Service for the medical examination of a seaman or apprentice during official hours be increased to £1 1s. when the examination was conducted at the surgery and £1 5s. when the examination was conducted at the home.

London House.

Dr. W. F. Simmons, the Honorary Treasurer, presented a statement setting out the donations which had been received for the period ended August 25, 1954, towards London House. The total sum subscribed, less exchange and bank charges, was £589 7s. 6d. Dr. Simmons said he was very disappointed with this result, which compared very unfavourably with that obtained for the Federal Council Medical Monograph Fund. He hoped that before long he would be able to send to London £625, which was the amount required for the "naming" of one room. Ways and means of increasing the amount of the contributions of the Branches were discussed.

Diploma in Obstetrics of the Royal College of Obstetricians and Gynæcologists.

At a previous meeting of the Federal Council reference was made to the recognition of the Diploma in Obstetrics of the Royal College of Obstetricians and Gynæcologists as a specialist qualification. A letter was then received from the acting honorary secretary of the Australian Regional Council of the Royal College of Obstetricians and Gynæcologists. In this letter it was stated that a diploma in obstetrics of the College was not of specialist standing, and was awarded to registered medical practitioners who had had special post-graduate training and experience in obstetrics only. The Regional Council sought the help of the Federal Council in an approach to the Queensland Government to alter the legislation so that doctors whose only qualification was the Diploma in Obstetrics of the College should not be registered as specialists. The matter at that time was referred to the Branches, and after receiving replies the Federal Council had resolved that it could not agree to recommend to the Queensland Government that the diploma should not be recognized for the purpose of specialist registration. The General Secretary reported that he had received a letter dated May 4, 1954, from the honorary secretary of the Australian Regional Council. In this letter the honorary secretary stated that the Federal Council's inability to support the Regional Council's approach to the Queensland Government had been received with regret, and the matter was brought again to the notice of the Federal Council. The reason why this matter was of such importance to the Regional Council was set out by the honorary secretary in the following terms:

1. The Diploma in Obstetrics of the Royal College of Obstetricians and Gynæcologists originated in Great Britain so that midwives would know which general practitioner to call to their aid when in trouble.

2. The standard of the examination is that of the knowledge expected of a general practitioner who includes obstetrics in his practice.

3. It is not a gynæcological diploma, nor is any gynæcological knowledge or training required by the applicant.

4. Candidates may be admitted to the examination without having had resident training in obstetrics.

5. The D. Obst. R.C.O.G. is not registrable in some of the States.

The matter was further discussed by the Federal Council. Dr. H. W. Horn quoted the regulations of the College and compared them with the statement made by the honorary secretary of the Australian Regional Council. He held that the latter statement was inaccurate in several respects. Dr. D. E. Copping and Dr. A. J. Murray supported the views of Dr. Horn, and the Federal Council resolved to reaffirm its previous decision—namely, "that as the Diploma in Obstetrics of the Royal College of Obstetricians and Gynæcologists is granted by the College following the fulfilment of prescribed conditions and examination, the Federal Council cannot agree to recommend to the Queensland Government that it is not to be recognized for the purpose of specialist registration".

Group Practice and the Use of Descriptive Titles.

A letter was received from the New South Wales Branch, dealing with the descriptive titles of group practices. In this letter it was stated that it had come to the notice of the Branch Council that with the formation of members into group practices some of the groups had decided to apply descriptive terms to themselves. The common practice was for a group to call itself a clinic, and to qualify this term by placing in front of it the name of the town in which the group practised. The Council had never approved of these descriptive titles being used in connexion with medical practices, and had advised groups which had used them to this effect. It would appear, however, that the practice of using such descriptive titles was carried on in other States. Recently when disapproval had been expressed of one group practising in a border town of New South Wales, a reply was received which indicated that the group had difficulty in understanding the Council's objection when the practice was allowed to go on in a neighbouring State. In view of the fact that the various Branches had different views on the matter, the New South Wales Branch Council felt that the matter might well receive the consideration of the Federal Council. In the discussion which followed the reading of this letter, it was pointed out that in some instances descriptive titles had been in use for more than twenty years, and that no exception had been taken to them. The replies received from some of the States showed that the objection was rather to the use of a geographical description than to any other. The Federal Council resolved that it was not opposed to the use of the term "clinic", but it was opposed to the title of newly formed clinics being associated with the name of a suburb, town or district.

The Australian Road Safety Council.

The General Secretary reported that he had received a letter from the Australian Road Safety Council, stating that the annual congress of the Council was to be held at Hobart from November 16 to 19, 1954. The Council wished the Federal Council to appoint a delegate to the congress. The Federal Council resolved that Dr. F. S. Hansman should be appointed as the representative of the Federal Council, to attend the congress. It was pointed out that Dr. Hansman had always taken a prominent interest in the question.

Votes of Thanks.

The Federal Council extended a vote of thanks to the Council of the Queensland Branch for its hospitality and for the accommodation provided for the meeting, and to Mrs. Spooner and her staff for their hospitality. The Federal Council also thanked Dr. A. E. Lee and Dr. H. W. Horn for their hospitality, and Dr. Hunter and Miss Cameron for their services during the meeting. On the motion of Dr. H. C. Colville the Federal Council carried a vote of thanks to Dr. A. J. Collins for the manner in which he had conducted the meeting.

Date and Place of the Next Meeting.

It was resolved that the date and place of the next meeting should be left in the hands of the President.

Correspondence.

THE LIFE INSURANCE MEDICAL RESEARCH FUND OF AUSTRALIA AND NEW ZEALAND.

SIR: The Life Insurance Medical Research Fund of Australia and New Zealand, which was established during 1952 by the Life Offices' Association for Australasia to promote and assist scientific and medical research on the diseases of the heart and blood vessels, has announced its awards for the year 1954.

The awards comprise eight grants-in-aid to various research departments throughout Australia and New Zealand. The total amount of the awards is about £25,000, approximately the same amount as was granted by the fund last year.

Details of the current year's grants-in-aid are as follows:

The Clinical Research Unit, Alfred Hospital, Melbourne: Grants for two research projects to be carried out under the direction of Dr. T. E. Lowe, Director of the Institute. The projects, which will extend over two or three years, concern the frequency analysis of cardiac vibrations (sounds) and energy production in the myocardium.

The Department of Pathology, University of Melbourne: For research, under the direction of Professor E. S. J. King, on the subject of dissecting aneurysm of aorta (effects of a chemical substance present in seeds of *Lathyrus odoratus*).

The Department of Pathology, University of Sydney: For research, under the direction of Professor F. R. Magarey, into the role of hypertension in arterial degeneration and in atherosclerosis.

The Department of Pharmacology, University of Sydney: For research, under the direction of Professor R. H. Thorp, on the subject of the electrical activity during cardiac contraction and the influence of drugs thereon.

The Hallstrom Institute of Cardiology, Royal Prince Alfred Hospital, Sydney: For the purchase of further equipment in connexion with the programme of research, already being supported by the fund under the direction of Dr. B. Sinclair-Smith, on the subject of pulmonary insufficiency and pathological lung changes seen in patients with mitral stenosis.

The Clinical Research Unit, Royal Prince Alfred Hospital, Sydney: For research under the direction of Dr. C. R. B. Blackburn, Director of the Unit, in the field of portal hypertension.

The Department of Medicine, University of Otago, New Zealand: For further research over the next two years, under the direction of Professor F. H. Smirk, on the problems of cardiodynamics including pathogenesis and treatment of hypertension.

Yours, etc.,
N. H. TAYLER,
Secretary, The Life Insurance Medical Research Fund of Australia and New Zealand.

13 Bond Street,
Sydney,
September 24, 1954.

THE COLLEGE OF GENERAL PRACTITIONERS: QUEENSLAND FACULTY.

SIR: We in Queensland were pleased to read of the progress of our sister faculty of the College of General Practitioners in New South Wales.

The inaugural meeting of the Queensland Faculty was held on Friday, August 27, following an inaugural dinner at the United Service Club, Brisbane (which was also attended by Professor J. W. H. Tyrer, the new occupant of the chair of medicine at the University of Queensland).

Dr. Paul Hopkins, of Mackay, was elected first President of the Queensland Faculty, and a Faculty Board was elected with Dr. H. S. Patterson, of Ipswich, as its chairman.

Criteria of membership were discussed and, while it is not envisaged that there will be any qualifying examination for membership or associate membership at present, the following criteria will be necessary: (*a*) A nomination for membership proposed and seconded by two members of the Queensland Faculty and approved by the Board of the Faculty. (*b*) A high standard of ethics for members, associates and applicants for membership or associate membership will be insisted on, and the Board may expel or reject on these grounds. (*c*) It is obligatory for those who have not been in practice for twenty years to agree to undertake the prescribed number of days' post-graduate training yearly, and compliance with this rule will be rigidly enforced. Membership of the Faculty involves responsibilities as well as privileges. (*d*) All applications for membership or associate membership living in Queensland will in future be sent to the Honorary Secretary of the College of General Practitioners, Queensland Faculty, 225 Wickham Terrace, Brisbane, and not direct to London.

In the not-too-distant future it may be possible for the New South Wales and Queensland Faculties (and those of other States which may subsequently be founded) to combine to form an Australian Council of the College.

With wise guidance the existence of a College of General Practitioners in Australia can only be productive of good.

Yours, etc.,
B. N. ADSETT,
Honorary Secretary, College of General Practitioners (Queensland Faculty).

225 Wickham Terrace,
Brisbane, B.17,
September 21, 1954.

Notice.

PRINCE HENRY'S HOSPITAL MEDICAL SOCIETY.

THE date of the clinical meeting of the Prince Henry's Hospital Medical Society previously announced as Tuesday, October 19, 1954, has been postponed to Tuesday, October 26, 1954, to avoid coincidence with the lecture by Dr. J. G. Scadding on the former date.

Medical Appointments.

Dr. K. F. McGovern has been appointed Resident Fellow in Pathology at the Mater Misericordiæ Hospital, North Sydney.

Dr. Mary Allen Hield has been appointed to the Baby Health Centres in the Department of Public Health, New South Wales.

Dr. R. G. Gold has been appointed medical registrar at the Royal Adelaide Hospital.

Dr. B. H. Guaran has been appointed a quarantine officer at Geelong, Victoria.

Diary for the Month.

OCT. 18.—Victorian Branch, B.M.A.: Finance Subcommittee.
OCT. 19.—New South Wales Branch, B.M.A.: Medical Politics Committee.
OCT. 20.—Western Australian Branch, B.M.A.: General Meeting.
OCT. 21.—New South Wales Branch, B.M.A.: Clinical Meeting.
OCT. 21.—Victorian Branch, B.M.A.: Executive of Branch Council.
OCT. 22.—Queensland Branch, B.M.A.: Council Meeting.
OCT. 26.—New South Wales Branch, B.M.A.: Ethics Committee.

Medical Appointments: Important Notice.

MEDICAL PRACTITIONERS are requested not to apply for any appointment mentioned below without having first communicated with the Honorary Secretary of the Branch concerned, or with the Medical Secretary of the British Medical Association, Tavistock Square, London, *W.C.*1.

New South Wales Branch (Medical Secretary, 135 Macquarie Street, Sydney): All contract practice appointments in New South Wales.

Queensland Branch (Honorary Secretary, B.M.A. House, 225 Wickham Terrace, Brisbane, B17): Brisbane Associated Friendly Societies' Medical Institute; Bundaberg Medical Institute. Members accepting LODGE appointments and those desiring to accept appointments to any COUNTRY HOSPITAL or position outside Australia are advised, in their own interests, to submit a copy of their Agreement to the Council before signing.

South Australian Branch (Honorary Secretary, 80 Brougham Place, North Adelaide): All Contract Practice appointments in South Australia.

Western Australian Branch (Honorary Secretary, 205 Saint George's Terrace, Perth): Norseman Hospital; all Contract Practice appointments in Western Australia. All government appointments with the exception of those of the Department of Public Health.

Tasmania: Part-time specialist appointments for the north-west coast of Tasmania.

Editorial Notices.

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All communications should be addressed to the Editor, THE MEDICAL JOURNAL OF AUSTRALIA, The Printing House, Seamer Street, Glebe, New South Wales. (Telephones: MW 2651-2-3.)

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